

A Fork in the Road *Obama, McCain, and Health Care*

by Michael Tanner

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Executive Summary

Health care reform will be one of the top issues of the 2008 presidential election. In the face of widespread public demand for changes in the U.S. health care system, both Barack Obama and John McCain have offered detailed proposals for reform.

Senator Obama's approach relies heavily on government mandates, regulations, and subsidies. He would mandate that employers provide health care coverage for their workers and that parents purchase health insurance for their children. He would significantly increase regulation of the insurance industry, establishing a standard minimum benefits package, and requiring insurers to accept all applicants regardless of their health. He would offer a variety of new and expanded subsidies to middle- and low-income Americans.

In contrast, John McCain emphasizes consumer choice and greater competition in the health care industry. He would move away from our current employment-based insurance system by replacing the current tax exclusion for employer-provided insurance with a refundable tax credit for individuals. At the same time he would sharply deregulate the insurance industry to increase competition.

Senator McCain's proposal is far from perfect, but from a free-market perspective, it appears superior to Senator Obama's plan. Obama's plan, with its heavy reliance on government, leads to the same problems that bedevil universal health care systems all over the world: limited patient choices and rationed care. McCain's proposal is much more consumer centered and taps into the best aspects of the free market.

Michael Tanner is a senior fellow at the Cato Institute and coauthor of Healthy Competition: What's Holding Back Health Care and How to Free It.

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Introduction

Our health care system is broken: expensive, inefficient, and poorly adapted to an economy no longer built on lifetime employment—a system that exposes Americans to insecurity and possible destitution.

—Sen. Barack Obama¹

Controlling health care costs will take fundamental change. Nothing short of a complete reform of the culture of our health care system and the way we pay for it will suffice.

—Sen. John McCain²

There is no doubt that voters see health care reform as a major election issue, with polls generally showing it trailing only the economy and the war in Iraq among voter concerns.³

This interest stems from an overwhelming dissatisfaction with the current state of the health care system. According to a November 2007 Gallup Poll, fully 56 percent of Americans believe that our health care system has major problems, and another 17 percent see it as being “in crisis.”⁴ Virtually every aspect of the health care system comes in for criticism. Not surprisingly, given the amount of attention paid to the uninsured, “access to care” is seen as the biggest problem, with “cost” a close second.⁵ But even the quality of health care, long a strong suit of the U.S. system, comes in for criticism, with 45 percent of voters believing that the quality of care is “poor” or “only fair.”⁶

Thus, it is not surprising that both Barack Obama and John McCain have offered detailed proposals for health care reform.⁷ In the broadest sense, both seek similar things. Both would increase the number of insured Americans (though both would fall short of universal coverage), and both seek to reduce the cost of health insurance and overall health care spending. In fact, both make cost control the highest priority of their plans.

However, the candidates differ significantly in how to achieve their goals. Senator Obama generally turns to the government for answers. His plan relies heavily on government mandates, regulations, and subsidies. On the other hand, with a few conspicuous lapses, Senator McCain leans toward deregulation and free market approaches to health care reform.

The results of these policies are likely to be very different for the American health care system. As Harvard University health professor Robert Blendon puts it, “It is one of the biggest philosophical debates we’ve had in a long time.”⁸ Voters this year will have a very clear choice.

Barack Obama

Senator Obama has said that if he were designing a health care system from scratch, his preference would be for a single-payer system “managed like Canada’s.”⁹ However, given both the infrastructure of the existing system and the political opposition to a single-payer system, he has proposed a less radical approach while hoping that “it may be that we end up transitioning to such a system.”¹⁰

Obama’s proposal is based on the concept of “managed competition.” Originally developed by Stanford University economist Alain Enthoven, among others, managed competition leaves the provision of health care in private hands, but within an artificial marketplace run under strict government control and regulation.¹¹ Insurers would operate much like public utilities. Risk management or underwriting would be prohibited, and the government would have at least some say over services provided and premiums. This is the same concept that formed the basis for the 1993 Clinton health care plan, Mitt Romney’s 2006 Massachusetts legislation, and Hillary Clinton’s 2008 campaign proposal.

Obama also appears to break somewhat with recent Democratic orthodoxy on health care reform by making the reduction of health care costs at least as central to his proposals as

achieving universal coverage. Coverage and costs are, of course, inextricably linked. But most Democrats, including Obama's primary opponents, were focused almost exclusively on the question of how to provide health insurance to those without it. That was the battle cry of Sen. Hillary Clinton, who promised to provide "health insurance for every single American."¹²

In contrast, Obama, while continuing to call his proposal a "universal health care plan," has focused more on a combination of regulations, cost cutting, and subsidies to reduce both overall health care spending and the price of insurance. He even appears willing to concede that universal coverage is not immediately achievable, and his own plan does not aim for 100 percent coverage.

Even so, Obama clearly seeks greater government control over the U.S. health care system. In his book, the *Audacity of Hope*, he argues that "the market alone cannot solve our health care woes—in part because the market has proven incapable of creating large enough insurance pools to keep costs to individuals affordable, in part because health care is not like other products or services (when your child gets sick, you don't go shopping for the best bargain)."¹³

As a result, he has been actively hostile to market-based reforms such as Health Savings Accounts, which he dismisses as being based on the idea that people have "an irrational desire to purchase more than they need."¹⁴ "The "freedom to choose," he argues, "magnifies the uneven risks and rewards of today's winner-take-all economy."¹⁵

Not Quite Universal Coverage

Throughout the Democratic primaries, one of the key points of contention between Barack Obama and Hillary Clinton was the question of an individual mandate.¹⁶ Clinton supported a requirement that every American buy health insurance, whereas Obama eschewed a mandate for adults. He would, though, require that parents purchase insurance to cover their children (generously defined as up to age 25).¹⁷

Obama argues that a mandate is unnecessary since Americans would buy health insur-

ance on their own if it were affordable. "My belief is the reason that people don't have it is not because they don't want it, but because they can't afford it," he says.¹⁸ Most of his proposals are focused on making health insurance more affordable, either by reducing the cost of the insurance itself or subsidizing its purchase.

He would require all employers to provide their workers with insurance through a "play-or-pay" mandate. Employers who do not provide "meaningful coverage" for their workers would be required to pay a penalty equal to some percentage of their payroll into a national fund that would provide insurance to those uncovered workers.¹⁹ Obama's campaign materials do not specify how much that penalty (which is effectively a tax) would be. However, similar proposals have ranged from 4 to 7 percent of payroll.²⁰

Obama also leaves undefined the term "meaningful coverage," although elsewhere he suggests that all insurance plans should offer benefits at least as generous as those provided through the Federal Employees Health Benefit Program.

Finally, Obama does not appear to make clear distinctions based on the size of the employer, although in one speech he did say that his mandate would apply to "all but the smallest businesses."²¹ Elsewhere he suggests that "very small businesses and startups" would be exempt.²² Campaign officials have said unofficially that the exemption would apply to "some number less than 15" employees.²³ It seems likely, therefore, that many of what would normally be considered small businesses would fall under the mandate. This is significant because small businesses are far less likely to offer insurance today. Roughly 45 percent of uninsured workers are employed by companies with 25 or fewer workers.²⁴

There are several problems with an employer mandate. First, while it might be politically appealing to claim that business will bear the new tax burden, nearly all economists would see it quite differently. The amount of compensation that a worker receives is a function of his or her productivity. The employer is gen-

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erally indifferent to the composition of that compensation. It can be in the form of wages, benefits, or taxes. What matters is the total cost of hiring that worker. Mandating an increase in the cost of hiring a worker by adding a new payroll tax does nothing to increase that worker's productivity. Employers will therefore seek ways to offset the added cost by raising prices (the most unlikely solution in a competitive market), lowering wages, reducing future wage increases, reducing other benefits (such as pensions), reducing hiring, laying off current workers, or outsourcing.

Low-skilled and low-wage workers would be particularly at risk. Roughly 43 percent of uninsured workers are working within three dollars of the minimum wage. The mandated insurance costs will represent a proportionately significant increase in the cost of employing those workers. At the same time, since wages are already low and those workers receive few other employment benefits, employers' ability to shift costs will be constrained. The most likely outcome will be greater unemployment for workers whose lack of skills does not justify the increased cost. Economists Katherine Baicker of Harvard and Helen Levy of the University of Michigan estimate that a nationwide employer health insurance mandate would result in the loss of approximately 315,000 jobs.²⁵ And, in Obama's case, the impact could be considerably worse since the candidate is also backing a "living wage," a significant increase in the minimum wage that would also lead to a substantial increase in the cost of employing low-skilled workers.²⁶

Second, by imposing an employer mandate, Obama would further lock us into our current employer-based health care system. Employer-based health insurance is an historical accident, stemming from a combination of labor shortages and wage-price controls during World War II. It limits consumer choice by giving decisions over insurance coverage to employers rather than workers. It means that workers who lose their jobs lose their insurance. And it means that individuals who do not receive employer-provided insurance face an increased financial burden

when they try to purchase insurance on their own.

Obama also undercuts his opposition to individual mandates by including a mandate for parents to provide coverage for their children. Surveys suggest that Obama is correct when he cites cost as the primary reason why people say they do not have health insurance.²⁷ It seems likely that, as he claims, if the cost of health insurance can be reduced more people will purchase it, even in the absence of a mandate. Moreover, it was the cost issue that led him to criticize Hillary Clinton's individual mandate that "forces everyone to buy insurance even if you can't afford it."²⁸

But that critique also applies to a mandate for covering children, which Obama supports. In fact, the critique is even more relevant since nearly 32 percent of uninsured children are in families with incomes below \$20,000 per year, and 63.9 percent are from families with incomes below \$40,000 per year.²⁹ Presumably Obama would suggest that the cost would be offset through the subsidies he would provide (see below), but Clinton proposed subsidies as well, and Obama still criticized her proposal.

Regardless, cost isn't the only problem. If Obama is going to require parents to insure their children, he will have to define what sort of coverage meets that mandate. Obama's campaign literature does not specify what benefits would have to be included. But, as with the business mandate, there is a suggestion that insurance must provide benefits at least as generous as the Federal Employees Health Benefits Program. That means many people who are providing insurance for their children today, and are perfectly happy with that insurance, may have to switch plans in order to comply with the requirements of the mandate.

No matter what level of benefits Obama initially requires, there will be enormous political pressure to expand the mandated package. Public choice dynamics are such that providers (who would make money from the increased demand for their services) and disease constituencies (whose members naturally have an urgent desire for coverage of their ill-

ness or condition) will always have a strong incentive to lobby legislators for inclusion under any minimum benefits package. The public at large will likely see resisting the small cost increase caused by any particular additional benefit as unworthy of a similar effort. It is a simple case of concentrated benefits and diffused costs.

One only has to look to Massachusetts to see that dynamic in action. Since implementing its individual mandate in 2005, the state has decreed that by January 2009, no one in the state will be allowed to have insurance with more than a \$2,000 deductible or total out-of-pocket costs of more than \$5,000. In addition, every policy in the state will be required to phase in coverage of prescription drugs, a move that could add 5–15 percent to the cost of insurance plans. A move to require dental coverage barely failed to pass and the dentists—along with several other provider groups—have not given up the effort to force their inclusion. Those additional mandates come on top of the 40 mandated benefits that the state had previously required, ranging from in vitro fertilization to chiropractic services.

Nor does Obama's own record inspire much confidence that he would resist the expansion of the minimum benefits package. During his time in the Illinois state senate, he voted for new mandated benefits every time they came to the floor, at least 18 times, without a single "no" vote.³⁰ And, although there are (as yet) few opportunities to vote on mandated benefits in the U.S. Senate, Obama was a cosponsor of legislation establishing a federal requirement that all insurers provide "mental health parity," one of the most expensive mandates.³¹

There is also the question of how Obama would enforce his children's mandate. His campaign literature is vague, although he suggests such options as making proof of insurance a requirement for enrolling children in school or day care.³² This is an important issue because insurance mandates are notoriously hard to enforce.

Again, Massachusetts provides an excellent example. The Massachusetts health plan

has reduced the number of uninsured in the state by slightly less than half, from 13 percent of residents to 7 percent. However, more than two-thirds of the newly insured are receiving free or subsidized coverage. The mandate itself has done little to reduce the number of uninsured.³³

Despite both the employer and children's mandates, Obama's plan would still fall short of universal coverage. Jonathan Gruber of the Massachusetts Institute of Technology estimates that Obama's plan would leave roughly 15 million Americans uninsured.³⁴ Obama disputes this estimate, and even Gruber concedes, "There is a lot of margin for error around that estimate."³⁵ Still, Obama's advisers admit that at least 2 million people would remain uncovered under his plan.³⁶

Both of these estimates, however, fail to take into account the impact of Obama's proposed regulatory policies, particularly his call for guaranteed issue and community rating (see below), which would likely increase the number of uninsured. And Obama's plans to restrict the ability of insurers to spend money on marketing could also make it less likely that there will be significant increases in voluntary coverage. The result is that significant numbers of Americans will remain uninsured.

A Heavy Regulatory Hand

Obama's preference for greater regulation and government control is not surprising since he believes that one of the primary reasons for the problems facing our health care system is greedy pharmaceutical and insurance companies "who pocket a growing chunk of the medical bills" paid by working people.³⁷ His speeches attack the salaries of health industry CEOs and drug and insurance company "profiteering."³⁸

Accordingly, Obama proposes a host of new regulations that would substantially reshape the insurance industry. He would require insurers to accept all applicants regardless of their health (guaranteed issue) and would forbid insurers from basing insurance premiums on risk factors such as health or age (community rating).

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Ironically, these policies are actually likely to increase the number of people who are uninsured. Although high-risk individuals are more likely to get insurance under such regulations, that gain is likely to be more than offset by the number of low-risk individuals who forgo coverage.³⁹ As the Congressional Budget Office has noted, community rating and guaranteed issue make it more likely that people will choose to go without health insurance.⁴⁰ For example, in the year after New York imposed community rating in 1993, an estimated 500,000 people cancelled their insurance.⁴¹

This happens because community rating raises premiums for young and healthy individuals, whereas both community rating and guaranteed issue reduce or eliminate the penalty for waiting to purchase insurance until a person is older or sicker. As a result, the young and healthy make the very logical choice to forgo health insurance, assuming that they can always purchase insurance later when they need it. It is as if you could buy retroactive auto insurance *after* you've had an accident. As healthy individuals leave the insurance pool, the proportion of those who are sick in the pool grows ever greater, leading to higher premiums which in turn causes the healthiest remaining individuals to leave in what amounts to an insurance death spiral.

This situation will leave Obama with two unpalatable choices. He can revert to the individual mandate that he currently opposes, in effect denying the young and healthy the option of opting out of the higher premiums. Or he can attempt to reduce the cost to those young and healthy individuals by increasing subsidies and significantly increasing the cost of his plan.

Obama also says he will force insurance companies to “pay a reasonable share of their profits on the patients they should be caring for in the first place.”⁴² Although some of his primary rivals favored a specific requirement that 85 percent of premiums be spent on providing care, Obama has not spelled out what he would consider “reasonable” nor what regulations he would favor to enforce such a restriction. He would, however, require insur-

ers to disclose the percentage of premiums that goes to patient care.⁴³

Such calls for a minimum pay-out level are politically popular, conjuring up the image of huge insurance industry profits and wasteful administrative overhead that can safely be dispensed with. But, the insurance industry today actually has a profit margin of just 5.5 percent for traditional insurers and only 3.8 percent for Health Maintenance Organizations.⁴⁴

And insurance overhead includes many useful services and programs. These include efforts to monitor patient care to ensure that those with chronic medical conditions are getting appropriate care (exactly the type of program that Obama says he wants to encourage) and efforts to combat fraud and abuse. Those programs can actually reduce overall costs and result in lower insurance premiums. Forcing insurers to abandon those efforts could have the perverse effect of increasing costs to consumers.⁴⁵

There have been a few state-level experiments with minimum payout requirements, notably in Kentucky and North Dakota, and the results are cause for concern. Insurers abandoned the market in those states and left consumers with fewer choices and higher premiums.⁴⁶

More generally, Obama promises to “investigate and prosecute the monopolization of the insurance industry.”⁴⁷ The concept of monopolization of the health insurance industry seems a bit odd, given that there are hundreds, if not thousands of insurers in the market. The American Association of Health Insurers has *more than 1,300 member companies*.⁴⁸

Finally, Obama would create a National Health Insurance Exchange, similar to the “Connector” that was a central feature of then-governor Mitt Romney’s plan in Massachusetts. The Exchange would have two functions. First, it would serve as a clearinghouse, providing information to consumers and providing one-stop shopping for health insurance. It would “evaluate plans and make the differences among the plans, including cost of services, public,” then assist individuals in purchasing

the insurance of their choice.”⁴⁹ In addition to private plans, the Exchange would also market the government-run option discussed below.

Second, it would act as a nationwide insurance regulator. The Exchange would establish “rules and standards for participating insurance plans to ensure fairness and to make individual coverage more affordable and accessible.”⁵⁰ The Exchange would also regulate premiums “so prices stay competitive and fair.” Obama does not say whether insurance companies would be free to offer policies for sale outside the Exchange, or if they could, whether the Exchange’s rules would still apply.

Although no mechanism is detailed, Obama promises that insurance purchased through the Exchange would be portable, meaning that workers could take it with them from job to job and could keep it if they lost their job. Presumably, workers would be able to take their employers contribution and purchase an individual policy through the Exchange. In Massachusetts that was accomplished by requiring employers to set up a “cafeteria plan” for their workers.⁵¹ That mechanism was largely an attempt to circumvent federal tax laws and might not be necessary under Obama’s plan.

Obama would also impose new controls on the pharmaceutical industry. As with the insurance industry, Obama frequently criticizes the pharmaceutical industry for “dramatically overcharging Americans for what they offer.”⁵² Specifically, Obama would have the federal government negotiate directly with drug companies to set prescription prices under Medicare Part D. And, he would allow the reimportation of drugs from Canada.

Both proposals are defensible in the abstract. Since in the case of Medicare Part D the government is the purchaser, there is no reason that the government shouldn’t be able to negotiate about what it pays just as it does with any other goods and services that it purchases. And consumers should be able to purchase goods at the lowest price they can find, even across borders. In practice, however, both proposals are likely to be implemented in ways that will have serious adverse consequences.

American research and development provides the innovation that produces most of the modern pharmaceutical breakthroughs that have helped cure diseases, improve the quality of life for millions worldwide, and saved countless lives. In fact, U.S. companies have developed half of all new major medicines patented worldwide over the past 20 years.⁵³

On average, it takes 12 to 15 years and costs as much as \$800 million before a company can bring a new drug to market.⁵⁴ Those costs must be recouped if innovation is to continue. As a practical matter, however, Americans end up paying for most of the costs of drug R&D while the rest of the world free rides. That is because most of the world imposes various levels of price controls and refuses to pay market prices. Because the actual production of drugs, as opposed to research and development, is relatively cheap, pharmaceutical companies have been able to segment their markets, selling drugs cheaper in other countries while U.S. consumers pay full cost. For example, brand-name drugs can cost as much as two-thirds more in the United States as they do across the border in Canada.

Ideally, if consumers were free to reimport those less expensive drugs from Canada, the pharmaceutical industry would respond by refusing to sell their product in Canada under that country’s price control regime. Canada would be forced to raise prices to market levels, and share some of the research and development costs. Prices would eventually seek an equilibrium: lower in the United States, higher in Canada.

Taken this way, reimportation would not only be unobjectionable, it would be a step toward freer markets generally.⁵⁵ However, Obama appears to lean toward a set of reimportation regulations that would prohibit companies from limiting supplies or raising prices abroad. In the Senate, he voted for the Pharmaceutical Market Access and Safety Act of 2004, sponsored by Sens. Byron Dorgan and Olympia Snowe, which would have allowed reimportation under precisely such a restrictive regime. Pharmaceutical companies

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would have been prohibited from trying to undercut other countries’ price controls.

In effect, allowing reimportation under these restrictions would simply create a “parallel market” with drugs being reimported from low-price to high-price markets. Eventually all drugs would go to the low-price markets, where companies can’t recover research and development costs, only to be reimported to high-price markets, effectively importing foreign price controls to our markets. As Senator Dorgan said, “It is my intention to force the pharmaceutical industry to re-price their drugs here in the United States.”⁵⁶ The results would be devastating for the future of pharmaceutical development.

In exchange for this risk, American consumers would see relatively little gain. Although some patients with very high drug costs would undoubtedly see substantial savings, the Congressional Budget Office found that allowing drug importation would reduce overall health care expenditures for the average American consumer by just one percent.⁵⁷

Similarly, allowing the government to directly negotiate prices under Medicare Part D would likely yield minimal gain in exchange for a great deal of potential pain. Private plans under Part D have already negotiated substantial price reductions. The CBO estimates that, unless Medicare were willing to impose rigid formularies that would deny beneficiaries access to many drugs, allowing the government to directly negotiate prices is unlikely to yield substantial additional savings.⁵⁸

But even if having the government negotiate with drug companies were somehow successful in reducing prices, any cost savings would come at the expense of pharmaceutical innovation. Benjamin Zycher, senior fellow at the Manhattan Institute, estimates that allowing Medicare to negotiate prices could reduce pharmaceutical research and development by as much as \$10 billion per year. That would substantially reduce the number of new drugs coming to market and translate into 5 million lost life-years annually.⁵⁹

Obama also raises the possibility of further regulating the medical profession. He would

establish a new government institute to conduct research on the comparative effectiveness of various types of treatment, medical technology, and drugs.⁶⁰ The goal would be to set practice standards based on efficiency and effectiveness. Obama does not say how such standards would be enforced, but a book by one of his closest advisers, former Senate majority leader Tom Daschle, suggests that the standards could first be imposed on government programs such as Medicare, Medicaid, and veterans’ programs. Daschle believes that private insurers would eventually adopt the standards as part of their reimbursement regime on a voluntary basis.

Although there is no doubt that Medicare, in particular, is largely indifferent to quality in its current reimbursement policies, there is reason to be concerned about whether the program is well-suited for pay-for-performance (P4P) measures.⁶¹ As a government program, Medicare is a creature of the political process. This means that the process of designing a P4P scheme will inevitably be subject to political interference and interest group lobbying that would likely lead to errors at the outset.⁶² Moreover, Medicare has a patient population with a disproportionately high incidence of chronic illness. As a result, a P4P scheme is likely to create incentives for physicians to avoid those patients or to mistreat them.⁶³ This does not necessarily rule out adopting P4P in Medicare, but it does suggest caution.

Obama hints at going further than applying P4P to government programs, calling for the Exchange to adopt P4P incentives for all policies that are sold through it. Elsewhere he has said that only plans that meet government established minimum standards for “high quality and cost control” would be eligible for participation in the Exchange, suggesting that he could make the practice standards mandatory for most insurance reimbursement.⁶⁴

More Subsidies, More Government Programs

Sen. Obama’s health care proposals envision both the expansion of existing govern-

ment programs and the creation of new ones. For example, he has said he will “expand eligibility for the Medicaid and SCHIP programs.”⁶⁵ Although Obama’s campaign does not specify how far an Obama administration would increase Medicaid and SCHIP eligibility, it is worth noting that in the Senate he voted for a proposal that would have allowed states to increase SCHIP income eligibility to 400 percent of the poverty level (\$83,000 for a family of four).⁶⁶ In addition, Obama would provide other subsidies for individuals with incomes above the SCHIP and Medicaid eligibility levels who still cannot afford insurance premiums. There are two significant dangers to subsidies of this magnitude.

First, the expansion of subsidies would greatly increase the number of people dependent on government. We can expect this new middle-class welfare benefit to generate many of the same problems that accompany other welfare programs, while creating a voting constituency for ever-expanding benefits.

Second, the subsidies are liable to squeeze out unsubsidized coverage. Many of those who would become eligible for Medicaid or SCHIP will already have health insurance. The expansion of these programs, then, should not be seen just as a method of increasing coverage, but as a way of shifting a large portion of insurance costs from individuals to the tax system. It becomes simply another form of income redistribution, as taxpayers are forced to pay at least part of the insurance bill for many people who are currently paying that bill for themselves.

This crowding-out phenomenon has been readily apparent with both the traditional Medicaid and SCHIP programs. A Robert Wood Johnson Foundation survey of 22 studies of the relationship between government insurance programs and private coverage concluded that substitution of government for private coverage “seems inevitable.”⁶⁷ Other studies have shown that when government programs are cut back, private coverage increases.⁶⁸ And, the Congressional Budget Office estimates that between one third and one half of children who would be added to

the SCHIP program were already covered by private health insurance.⁶⁹

In addition, Sen. Obama has talked about creating some form of reinsurance mechanism to protect employers against catastrophic health costs. If an employer’s health care costs exceed some unspecified amount, the government will “pick up the tab,” as long as the employer agrees to pass any savings back to workers.⁷⁰ The Obama campaign provides few details about how this reinsurance program would work, but a similar plan was proposed by Sen. John Kerry during the 2004 presidential campaign.⁷¹

A reinsurance program would almost certainly reduce insurance premiums for employers. It is not a really a cost-cutting mechanism but rather a cost-shifting mechanism. It would simply move health care costs from employers and employees to taxpayers. More importantly, by adding another layer of insulation between health care consumers and costs, the program could actually lead to increased costs. Once an employee’s health care costs reach the cutoff point and shift to the government, both the employer and employee lose any incentive to manage costs.

Finally, and most significantly, Senator Obama would create a new government-run health care program that would operate as a voluntary alternative to private health insurance. It would be available through the Exchange for those Americans who are not eligible for any other government program such as Medicare or Medicaid and who do not receive insurance directly through their employer. Small businesses and the self-employed would also be able to participate.

Obama offers few details about what the program would be like, but in the *Audacity of Hope*, he suggests that he would have an independent organization—perhaps the federal Institute of Medicine—“determine what a basic, high-quality health-care plan should look like and how much it should cost.”⁷² Private insurers would be able to bid to manage the program, but would be required to meet criteria for quality established by the IOM.⁷³ The government would also impose cost con-

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trols.⁷⁴ The plan might be offered through the Federal Employees Health Benefits Program or through separate programs established regionally or in each state.⁷⁵ If the latter, the plan would closely resemble the regional purchasing pools proposed under the 1993 Clinton health plan.⁷⁶

Regardless of how it was structured or administered, such a government-run plan would have an inherent advantage in the marketplace because it would ultimately be subsidized by American taxpayers. The government plan could, for instance, keep its premiums artificially low or offer extra benefits since it can turn to the U.S. Treasury to cover any shortfalls. Consumers would naturally be attracted to the lower-cost, higher benefit government program, undercutting the private market. And, this would be taking place even as Obama's proposed regulations were making it harder for private insurance to market its products or target products to specific consumers. The result will be a slow but inexorable slide toward government-run health care.

Costs

Obama's campaign has variously estimated the cost of his plan to taxpayers as between \$50 billion and \$65 billion per year.⁷⁷ The campaign suggest that his plan could be paid for by repealing the Bush income tax cuts for the top two brackets, increasing the taxes on dividends and capital gains to Clinton-era levels, and restoring the estate tax (with a \$7 million exemption).⁷⁸ However, Obama has also suggested that the funds from repealing the Bush tax cuts would be available to finance Obama's other spending initiatives, which have been estimated at \$300 billion–\$800 billion per year.⁷⁹ Clearly, some additional taxes would therefore be necessary to pay for Obama's health care plan.

One place where he has suggested that he might find additional funding is by capping or otherwise restructuring an employer's ability to deduct the cost of providing health insurance to their workers. Employers would continue to be able to deduct the costs up to the cost of the government-designed stan-

dard package, but would not be able to deduct the cost of providing "fancy, gold-plated executive health-care plans that fail to provide any additional health benefits."⁸⁰

It is important to understand that this is a very different proposal from plans to cap or eliminate the tax exclusion for employer-provided insurance. The Obama plan is not designed to shift us away from an employer-based system—given Obama's support for an employer mandate, that would be impossible anyway. Rather, it would simply push all employers to offering uniform insurance plans. The goal is not to create greater choice, but fewer choices.

Moreover, the Obama campaign may be underestimating the actual cost of his plan. Jonathan Gruber puts the cost much higher, perhaps as much as \$102 billion per year.⁸¹ There are also some items within Obama's plan that do not yet have specific price tags. For example, it is impossible to know how much Obama's proposed expansion of Medicaid and SCHIP will cost without knowing income eligibility levels. The bill that he voted for in the Senate would have increased spending by roughly \$35 billion over five years. Similarly, without knowing more details, the exact cost of his catastrophic reinsurance pool is impossible to determine, although some observers warn that it could be quite expensive.⁸²

Obama claims that despite the program's cost most people will come out ahead because other parts of his program will reduce premiums by up to \$2,500 per year.⁸³ In particular, Obama touts savings from the following:

Increased investment in health care IT technology. Obama would spend \$50 billion on health IT over the next five years. The campaign cites a Rand Corporation study that suggests wider use of health IT could save \$77 billion per year by making the health care system more efficient.⁸⁴

Improved disease management, better coordination of care, best practices research, and pay for performance. The campaign points to a study by Kenneth Thorpe of Emory University that estimates that 80 percent of health care spending is associated with

chronic illness. According to Thorpe, better management of care for patients with chronic diseases would result in substantial savings.⁸⁵ The campaign also cites a Rand study that predicts savings of up to \$81 billion per year from increased prevention and better disease management.⁸⁶

Reducing administrative costs and insurance overhead. As noted above, Obama would heavily regulate the insurance industry and believes that doing so would significantly reduce costs. The campaign does not link any particular regulation with specific savings, although it believes that the savings could be as much as 12 percent of premiums.⁸⁷ Although it does not offer a specific basis for that number, it does point to a Commonwealth Fund study that estimates savings of \$32 billion to \$46 billion per year from bringing the insurance industry's cost structure in line with that of other countries.⁸⁸ All told, Obama's advisers suggest that his proposals would reduce total health care costs in the United States by \$120 billion to \$200 billion per year.⁸⁹

But there is ample reason to be skeptical of these predicted savings. The *New York Times* editorial board notes that "there is little certainty about how much those [cost saving] initiatives might save, or when. Nor can it be known if the savings would offset the potential cost of new technology and drugs and the cost of providing care to the newly insured."⁹⁰

For example, preventive care advocates assume that if we focus on preventive medicine, we can prevent people from getting sick in the first place. And by emphasizing timely primary care, those who do end up with a chronic illness will develop fewer complications. By spending money up front to reduce the frequency and severity of illness we can reduce the amount of money needed to eventually treat those illnesses in the future.

As logical as this may seem, studies actually show that preventive care usually ends up costing money in the long run because there is no way to precisely target such care.⁹¹ For every disease that we prevent or catch early, we end up testing and treating many people who will never get sick. For example, Jay Bhattacharya,

a doctor and economist at Stanford's School of Medicine, estimates that to prevent one new case of diabetes, an anti-obesity program must treat five people.⁹² Similarly, a study of retirees in California by Jonathan Gruber found that when retirees had fewer doctor visits and filled fewer prescriptions, overall medical spending declined.⁹³ People became ill more frequently, but treating their illnesses was still less costly than paying for preventive care for everyone. Thus, increased preventive and primary care may well be beneficial for the individual in terms of health, but may not provide a societal benefit in terms of reduced costs.

As an article in the *New England Journal of Medicine* concluded, "Our findings suggest that the broad generalizations made by many presidential candidates can be misleading. These statements convey the message that substantial resources can be saved through prevention. Although some preventive measures do save money, the vast majority reviewed in the health economics literature do not."⁹⁴

The Obama campaign may also be overestimating the savings available from reducing the administrative cost of insurance. Many proposals to reduce administrative costs rely on an unrealistic estimate of what is achievable. They start with a low estimate of administrative costs under government-run systems, both foreign national health care systems and U.S. government programs such as Medicare, and suggest that the administrative costs of private insurance can be squeezed down to similar levels. However, the administrative costs of government-run health insurance may be much higher than commonly believed. For example, a study by Patricia Danzon of the Wharton School suggests that administrative costs under Canada's national health care system actually exceed those of private U.S. insurance.⁹⁵ And a study by Benjamin Zycher concludes that any savings from government administration would be insufficient to offset the costs of increased coverage.⁹⁶

And, as mentioned above, many insurance programs that fall under the definition of administrative cost are beneficial and actually

Clearly, some additional taxes would be necessary to pay for Obama's health care plan.

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reduce overall costs and/or improve patient outcomes. An arbitrary reduction could end up harming consumers.

John McCain

While health care reform was a central issue of the Democratic presidential campaign, it was far less important in the Republican primaries. For that reason, among others, John McCain has had less to say about health care than Barack Obama has so far. Still, he has put forward a relatively detailed reform proposal—one that heads in a totally different direction than that taken by Sen. Obama.

McCain rejects “coercion and the use of state power to mandate care, coverage, or costs.”⁹⁷ Rather, he says he would “reform the system through the mechanism that has made the American economy the envy of the world—free markets and competition.”⁹⁸

Even more than Obama, McCain breaks with the conventional wisdom that any health care reform plan should be primarily concerned with extending coverage to the uninsured. Instead, he says that he sees the cost of health care as the most important problem facing the system and would not “immediately focus . . . on a promise of universal coverage.”⁹⁹ As one of McCain’s top advisers put it: “You worry about the uninsured, but they are a symptom of a larger problem. Unless you do something about cost, you are chasing your proverbial tail.”¹⁰⁰

Because he is advocating market-based reforms rather than government programs, many observers fail to appreciate just how radical an approach McCain is taking. Far from a defense of the status quo, his plan would significantly change the way health care and health insurance are purchased, delivered, and paid for. “If you take his platform en masse, and begin with his premise that it’s about cost and not access, then you can pretty much declare a jihad against all the stakeholders in the system,” said Paul Keckley, director of the Deloitte Center of Health Solutions.¹⁰¹

Confronting the Employer-Based System

At the heart of McCain’s proposal is a fundamental shift in the way we purchase insurance. Currently, some 70 percent of Americans receive insurance through their place of employment.¹⁰² As discussed above, employment-based insurance hides much of the true cost of health care to consumers, thereby encouraging overconsumption. It also limits consumer choice, since employers get the final say in what type of insurance a worker will receive. It means that people who don’t receive insurance through work are put at a significant and costly disadvantage. And, of course, it means that if you lose your job, you are likely to end up uninsured as well.

McCain would move us away from our employer-based system. He would count at least some of a worker’s employer-paid insurance as taxable income.¹⁰³ (The campaign is unclear about whether it would completely eliminate the tax exclusion or simply cap it at some level). At the same time, he would provide all Americans with a refundable \$2,500 tax credit for individuals and \$5,000 for families (regardless of how people obtain their insurance).¹⁰⁴ Unlike some other tax credit proposals, the McCain plan does not have an income eligibility cut-off or phase-out. His campaign has also said that he is willing to consider risk-rating the credit to provide additional help to people with existing health problems that might raise their premiums (meaning the sick could receive a larger credit).¹⁰⁵

Some critics of Senator McCain’s proposal have misinterpreted or misstated what this proposal actually means. They point out that a \$2,500 or \$5,000 tax credit would be insufficient to purchase an insurance policy. They suggest that McCain’s plan would leave health insurance unaffordable and, if it encouraged employers to drop their coverage, millions of Americans would face significant new costs or be left uninsured.

But McCain is not suggesting that the tax credit be used to pay for insurance (except for the currently uninsured, for whom any help is better than what they have today). Rather, he is creating an incentive for employers to take the

money they are currently using to buy health insurance for their workers and give that money to employees. Since on average employers pay \$8,824 for a worker's insurance, that is roughly what workers could expect to receive. The tax credit merely offsets the extra taxes that the worker would otherwise have to pay if he or she received that \$8,824 as additional wages.

Of course, if you replace an unlimited tax break with a limited tax break, some people are liable to pay higher taxes. The McCain campaign suggests that a worker in the top tax bracket whose employer contributes more than \$14,285 per year toward paying for his or her insurance could still end up with a tax increase under this trade-off.¹⁰⁶ According to the Kaiser Family Foundation, just 6 percent of workers are employed by companies where the average employer contribution exceeded \$14,000, and not all of those workers are in the top tax bracket.¹⁰⁷ Nearly all lower- and middle-income workers would end up better off. For example, according to McCain's campaign, a typical worker in the lowest tax bracket could expect to pay about \$1,500 in taxes and keep the remainder of the \$5,000 tax credit.¹⁰⁸ Critics note that this tax advantage may not last. The size of the tax credit would grow only at the rate of inflation, which is below the rate of growth in health insurance premiums.¹⁰⁹ At the same time, this might actually be a benefit of Sen. McCain's proposal since it would encourage people to be more thrifty in the purchase of health insurance, choosing high deductible policies for example.

The McCain campaign does not offer any estimates of how much his proposal will increase coverage. Analysis of other tax credit proposals, most of which are more targeted to low-income workers than the McCain proposal, suggest that there would be a relatively modest take-up rate among the currently uninsured. That is because the uninsured, particularly low-income uninsured, are likely to be extremely price sensitive, and the tax credit is worth less than cost of a typical insurance policy. For those with employer-provided insurance today, this is not an issue since the plan envisions employers either continuing to

purchase the insurance or shifting compensation from insurance to wages. But for those uninsured today, the difference between the cost of purchasing insurance and the amount of the credit represents a new expense.

As a result, an earlier Bush administration proposal for a refundable \$1,000 tax credit targeted to workers with incomes under \$30,000 would have insured only an additional 1.6 million individuals.¹¹⁰ Similarly, the Bush administration's proposal for replacing the current tax exclusion with a standard deduction was projected to increase the number of insured Americans by about 9.2 million people.¹¹¹

The McCain proposal offers a considerably more generous credit (and a credit rather than a deduction) and will correspondingly have a higher participation rate. If the tax credits are risk-rated, that will also increase the number of people who get insurance. Moreover, because there is no upper income limit on eligibility for the credit, the McCain plan would also reach those middle-income uninsured who may be less price sensitive and better able to navigate the individual insurance market. And finally, the McCain tax credit should be analyzed in conjunction with the regulatory changes discussed below, which are designed to make individual insurance more available and easier to purchase. Looking at all of these factors, Steve Parente, professor of finance at the University of Minnesota, estimates that the McCain plan would increase the number of people with insurance by 23 million to 27 million.¹¹²

Moving from an employer/group based insurance system to one based on individually purchased and owned insurance has left Senator McCain open to criticism that his proposal would disadvantage those with pre-existing conditions who often find it difficult to find affordable coverage in the individual insurance market.¹¹³ Elizabeth Edwards, wife a former Democratic presidential candidate John Edwards, claimed that under McCain's plan, insurance companies "wouldn't have to cover preexisting conditions like melanoma and breast cancer."¹¹⁴ Indeed, unlike Senator Obama, McCain would not require either

McCain would move us away from our employer-based system.

By making insurance more affordable to the young and healthy, McCain's plan will attract them into the market before they develop preexisting conditions.

guaranteed issue or community rating for health insurance.

However, as noted above, McCain has considered risk-rating the tax credit that he would offer, meaning more money would be available to those facing higher insurance costs. He would also provide federal funds to help subsidize state efforts to cover individuals with preexisting conditions.¹¹⁵ McCain offers few details about exactly what state mechanism or mechanisms he would support. Rather, he has said that he would work with governors to find a “best practice model” for creating a “Guaranteed Access Plan” that would cover the medically uninsurable. He has described a potential GAP as a nonprofit designed to include procedures that better manage chronic illness and reduce costs. He has also mentioned both “high-risk pools” and states that designate Blue Cross as an “insurer of last resort” as potential models.¹¹⁶ Senator McCain has made only the vaguest calculations of how much federal assistance he would need. His aides have suggested that it could cost \$7 billion–\$10 billion per year, but that projections “could change dramatically depending on how the program was structured.”¹¹⁷ He has not specified a funding source, but has raised the idea of diverting some Medicaid funds into the program.¹¹⁸

In essence, as Jonathan Gruber has pointed out, using government funds to finance an insurance plan for the otherwise uninsurable simply shifts the subsidy process from the insurance system to the tax system.¹¹⁹ This seems far more efficient, less regressive, and less distorting than guaranteed issue and community rating.

That is, unless the program becomes too proscriptive—Senator McCain mentions requiring GAPs to provide every patient with “nurse care managers”¹²⁰—or the federal financing becomes simply another revenue windfall for the states. (State governments already use Medicaid as a way to shift costs from state to federal taxpayers.)¹²¹ And, given that some 33 states already have high-risk pools and 4 others designate an insurer of last resort, a new federally imposed program seems unnecessary.

Beyond such direct interventions, the

McCain campaign maintains that the senator's proposal would make insurance more affordable for everyone, including those with preexisting conditions.¹²² In particular, by making insurance more affordable to the young and healthy, McCain's plan will attract them into the market before they develop preexisting conditions. And McCain has mentioned that deregulation will likely lead to the creation of new and innovative insurance products that may help deal with these problems.¹²³ Although McCain has not offered any details of what these insurance products would look like, Switzerland, which has a health system that in some ways resembles the one that Senator McCain has talked about, has begun experimenting with “long-term” health insurance policies.¹²⁴

Changing “How” Health Care Is Paid For

Fundamental to McCain's vision of health care reform is changing not just *who* pays for health care, but *how* that health care is paid for. Essentially McCain wants to challenge the concept of traditional “fee-for-service” medicine. “We should pay a single bill for high-quality healthcare, not an endless series of bills for pre-surgical tests and visits, hospitalization and surgery, and follow-up tests, drugs and office visits.”¹²⁵ As a McCain staffer puts it. “You don't want to pay per procedure. You want to pay per episode, per outcome.”¹²⁶

However, McCain provides few details about how he would implement such a change. It seems likely that he would focus on government programs such as Medicare and Medicaid. As noted, Senator Obama has called for greater use of pay-for-performance and quality standards in how the government reimburses under these programs. But Senator McCain wants to go much further, virtually ending the government's reimbursement on a fee-for-service basis.

Currently, Medicare hospital reimbursements are based on Diagnosis Related Groups, some 500 payment categories based on factors such as diagnoses, procedure, age, sex, and the presence of complications. As McCain's top health adviser puts it, this is “built on the false

idea that Congress knows best the price schedule for all physician services.”¹²⁷ Instead, under McCain’s proposal, physicians treating a diabetic patient would be compensated on such things as how well they control the patient’s blood sugar rather than getting paid on a per-visit basis.¹²⁸

Although McCain’s proposed reforms to the way we pay for health care reflect a growing consensus among health care reformers, there are reasons to be cautious about whether Medicare serves as the best platform to initiate reform—for much the same reason that it may not serve as the best vehicle for Obama’s suggested injection of pay-for-performance.

McCain also rightly calls for greater transparency for health care costs and prices. “Families, insurance companies, the government—whoever is paying the bill—must understand exactly what their care costs and the outcome they received.”¹²⁹

Deregulation (mostly)

Whereas Senator Obama’s plan relies heavily on new regulation, Senator McCain generally calls for deregulation, particularly in the area of insurance.

Most notably, McCain would allow people to purchase health insurance across state lines, a practice that is currently prohibited by state laws. Since health insurance is largely regulated at the state level, one of the major reasons that costs differ so from state to state is because of the varying regulations and mandates that states have chosen to impose. For example, New Jersey has imposed more than 40 mandated benefits, including in vitro fertilization, contraceptives, chiropractors, and coverage of children until they reach age 25.¹³⁰ The state has also adopted community rating and guaranteed issue. In part as a result of this, the cost of a standard health insurance policy for a healthy 25-year-old man would average \$5,580 in the state. A similar policy in Kentucky, which has far fewer mandates and no community rating or guaranteed issue, would cost the same man only \$960 per year.¹³¹ Unfortunately, consumers are more or

less held prisoner by their state’s regulatory regime. It is illegal for that hypothetical New Jersey resident to buy the cheaper health insurance in Kentucky.

In contrast, if consumers were free to purchase insurance in other states, they could in effect “purchase” the regulations of that other state. A consumer in New Jersey could avoid the state’s regulatory costs and choose, say, Kentucky, if that state’s regulations aligned more closely with his or her preferences. Many consumers would undoubtedly choose less regulation. For example, young and healthy individuals with low incomes may choose not to buy coverage that forces them to subsidize older, sicker (and generally wealthier) individuals. For those risk-adverse individuals who prefer greater regulatory protection, the cost of those protections would be reflected in higher premiums.

Senator McCain’s proposal would permit this type of interstate competition. With millions of American consumers balancing costs and risks, states would be forced to evaluate whether their regulations offered true value or simply reflect the influence of special interests. As McCain says, “nationwide insurance markets that ensure broad and vigorous competition will wring out excessive costs.”¹³²

McCain would also allow people to purchase insurance through nontraditional groups. Today, three types of organizations can offer group insurance: employers, unions, and trade associations. McCain would open this to other groups, notably churches and professional organizations.¹³³

More problematically, he would also allow small businesses to band together in “association health plans” (AHPs) to gain benefits from pooling their risks. That makes sense if the AHPs can choose among competing state regulations, but there are reasons to be concerned over creating federally regulated AHPs. Doing so would be a step toward greater federalization of insurance regulation. As costly and damaging as much insurance regulation is today, it is at least somewhat restrained by the fact that special interests are forced to lobby in 50 state capi-

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tals. Moving the locus of insurance regulation to Washington would simply create a “one-stop shopping” center for lobbyists.

On the supply side, McCain supports “innovative delivery systems, such as clinics in retail outlets and other ways that provide greater market flexibility in permitting appropriate roles for nurse practitioners, nurses, and doctors.”¹³⁴ His campaign speaks of health care being offered through a variety of venues such as “Minute Clinic, COSTCO, banks, investment companies, hospital or health companies such as Wellpoint, Humana or online services such as Revolution Health, Google Health, etc.,” with the government’s role limited to establishing “some standards of transparency, solvency, etc.”¹³⁵

He has also called for “different licensing schemes for medical providers.”¹³⁶ In particular, McCain has suggested that some types of care could be shifted to nurse practitioners and other allied health personnel. “We need to have flexibility in the delivery of care so physicians can spend more time on the tasks they’re suited for,” a McCain advisor explained.¹³⁷ Although most medical licensing and scope-of-practice laws are a state, not a federal, purview, there are some actions McCain could take in this area, particularly in terms of federal reimbursement policies.

Unfortunately, not all of Sen. McCain’s proposals are free-market oriented. McCain was a co-sponsor (along with Sens. Edward Kennedy and John Edwards) of the Patients’ Bill of Rights in 2001, which would have regulated Health Maintenance Organizations.¹³⁸

In particular, that legislation would have allowed lawsuits against HMOs (and potentially employers, some argue) in federal courts over denial of claims. Of greater concern, the legislation also contained an “any willing provider” requirement, meaning health plans could not limit which physicians could participate in their plans.

McCain seems particularly hostile to the pharmaceutical industry, sometimes employing Obamaesque language in attacking drug companies. For example, during a Fox News primary debate, former Massachusetts gover-

nor Mitt Romney admonished McCain, “Don’t turn the pharmaceutical companies into the big bad guys.” McCain’s response: “Well, they are!”¹³⁹

In practice, there appears to be little difference between McCain’s policies toward the drug industry and those proposed by Obama. Like Obama, McCain would have the federal government negotiate directly with drug companies to set prescription prices under Medicare Part D and allow the reimportation of drugs from Canada. Like Obama, he voted for the Pharmaceutical Market Access and Safety Act of 2004. In fact, McCain expressly decried drug companies that, “putting profit before patients . . . have limited the supply of pharmaceuticals to Canadian pharmacies and wholesalers.”¹⁴⁰

And, as with Senator Obama, Senator McCain’s pharmaceutical proposals are unlikely to achieve the savings he envisions. Moreover, any savings that they do achieve would potentially come at the expense of pharmaceutical research and development, reducing the number of new drugs brought to market and ultimately costing lives.

Finally, McCain has pledged to streamline and reform the FDA bureaucracy, although it is not entirely clear whether his approach will actually reduce regulation. While generally supportive of measures to make the agency more efficient, he has also supported proposals to expand its regulatory reach (including cosponsoring a proposal to give the FDA authority to regulate tobacco).¹⁴¹

Scaling Back Government Programs

Whereas Obama wants to expand most government health care programs, McCain is calling for measurers to reduce their costs. McCain was one of only five Republican senators to vote against the Medicare prescription drug benefit and remains critical of the program. He has now called for means-testing the program so that couples with incomes of more than \$164,000 would not receive subsidized coverage.¹⁴²

During his time in the Senate, McCain has consistently sought to reduce Medicare

costs—a program he describes as “hurtling toward bankruptcy.”¹⁴³ For example, he has voted in support of provisions that would increase the age for Medicare eligibility to 67, impose a new \$5 copayment for home health care visits, and means test the program generally. He also voted to gradually raise the Medicare eligibility age from 65 to 67 between 2003 and 2027.¹⁴⁴ In 2005, he voted to cut Medicare spending by \$6.4 billion by requiring that beneficiaries purchase medical equipment and cutting payments to home health care providers.¹⁴⁵ He has said that he would be willing to “consider” ending the subsidy for Medicare Advantage.¹⁴⁶

McCain voted against the Democrats proposed expansion of SCHIP, arguing that “the program has expanded beyond what Congress first intended. In some cases, SCHIP coverage has been extended to middle-income children and to certain adult populations.”¹⁴⁷ Beyond, the program’s costs, he has criticized the proposed expansion as an “incremental government control of health care.”¹⁴⁸ However, he supported a proposal by President Bush that would have increased SCHIP spending by \$20 billion over five years, although it would not have expanded eligibility for the program. And Senator McCain voted for the creation of SCHIP in 1996.¹⁴⁹

Although he has not discussed it in the context of the current campaign, in the past McCain has supported proposals to block grant Medicaid funds and return responsibility for the program to the states in much the same way as was done with cash welfare (TANF).¹⁵⁰

Finally, McCain would privatize many veterans’ health care services, allowing veterans to seek care outside the current system. He would provide every veteran with a fully funded health account with a “swipe card” that would provide access to existing VA facilities or could be used to pay for private doctors and hospitals.¹⁵¹

Cost

The McCain campaign has not provided any estimate of how much his health care

proposals would cost. Nor has there been any comprehensive independent analysis. Still, one can assume that the overall cost will be modest since Senator McCain calls for relatively few new spending initiatives.

The most expensive part of his proposal is the refundable tax credit. That cost would be offset by eliminating the current tax exclusion for employer-provided insurance. The Bush administration’s proposal for a standard deduction (discussed above) was projected to have a net revenue *gain* to the Treasury of \$14 billion.¹⁵² Since the McCain tax credit is refundable and likely to have a much higher take-up rate, it is unlikely to produce a positive cash flow and will, in fact, likely have a small net cost. And risk-rating the credit would increase costs as well. The National Taxpayers Union suggests the net cost of McCain’s tax credit approach would be around \$3 billion per year.¹⁵³

Other costs and savings under McCain’s plan are far less clear. For example, if elected would McCain seek to expand SCHIP as much as would President Bush? What savings could he expect from reforming Medicare? What will be the actual cost of the Guaranteed Access Plan?

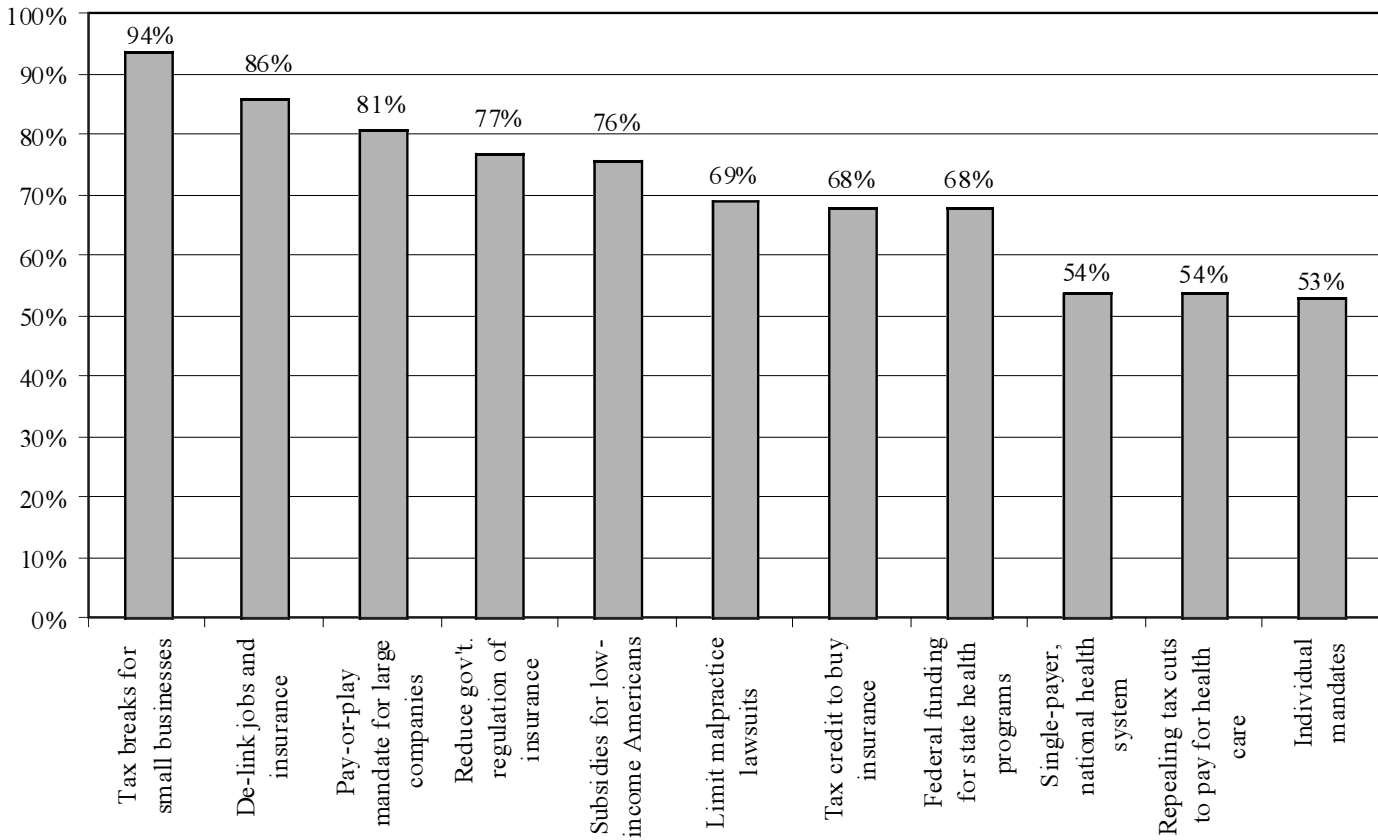
Like Obama, McCain assumes that greater efficiency and a focus on preventive care will reduce health care costs. And as with Senator Obama, those assumptions should be approached with a great deal of skepticism. Indeed, most of the criticism leveled against Obama’s plan for “unrealistically high assumptions” about projected savings applies equally to Senator McCain and his plan.¹⁵⁴

Conclusion

Historically, Democrats have enjoyed an electoral advantage on health care, and—in the abstract—this year seems no different. When asked which party they would prefer to see handle health care reform, voters prefer Democrats by a margin of 52 to 36.¹⁵⁵ However, when it comes to specific ideas for reform, voter preferences are far less clear, and

**Unfortunately,
not all of
McCain’s
proposals are
free-market
oriented.**

Figure 1
Favored Health Care Reforms



Source: “Any Healthcare Reform Will Do for Americans,” Gallup Polls, October 25, 2007.

that may make for a much more wide open debate.

A recent Gallup poll showed more than half of all Americans supporting every suggested health care reform, from the most market-oriented policies to total government control (see Figure 1).¹⁵⁶ More than half of voters said yes to a government-run single-payer healthcare system. But an even larger majority—more than 77 percent—favored “reducing government regulation of insurance.” Roughly 81 percent of voters support a requirement that employers provide health insurance to their workers—a proposal supported by Democratic presidential nominee Barack Obama. Yet 86 percent want to do away with employment as a prerequisite for health insurance, along the lines of a proposal by Republican nominee John McCain. Two-thirds

also agree with McCain’s call for a health care tax credit, but 77 percent agree with Obama that we should increase subsidies for low-income Americans to help buy insurance, and 54 percent would repeal the Bush tax cuts to do it.

Essentially, voters are saying that almost anything is better than the status quo. The candidate who makes the better case for his reform will find a responsive public.

This year, the candidates offer dramatically contrasting visions for reform. Interestingly, they start from a similar point. Breaking from the conventional wisdom of the recent health care reform debate, neither offers a proposal for truly universal coverage, though both would expand coverage significantly (particularly Senator Obama). Rather, both McCain and Obama recognize that the key question in

health care reform is not coverage but cost. In so doing, they are reflecting a growing belief among health care experts that the continued growth of health care spending is unsustainable and that something must be done to bring costs under control. The United States spends roughly 17 percent of its Gross Domestic Product on health care, far more than any other country, and that is projected to rise to 20 percent of GDP by 2015.¹⁵⁷ Although that spending has undoubtedly helped buy the highest quality health care in the world, the distribution of costs has clearly made care unaffordable for many businesses and individuals. Nor should we forget that the skyrocketing cost of government health care programs like Medicare and Medicaid is threatening to bury our children under a mountain of debt and taxes.

That is not to say that Obama and McCain agree on *how* to reduce health care costs. Obama would rely much more on the heavy hand of government. Among other things, he would impose de facto price controls on insurance premiums and drug companies. He would have the government establish national practice standards for doctors. And, he would create a National Health Insurance Exchange as a sort of clearinghouse to make it easier for businesses and individuals to shop for the best insurance.

McCain, in contrast, would attempt to promote greater competition among private health insurers. He would allow people to buy insurance plans across state lines, which will help drive down rates. And he would try to shift away from our current employment-based insurance system toward a system where individuals purchase and own their own insurance plans.

Both Senators Obama and McCain tend to claim uncertain and unproven savings from painless steps such as preventive care and administrative simplification. There simply is no magic bullet to reduce health care costs, but neither campaign seems willing to admit it. McCain, however, seems somewhat more willing to admit that hard choices will be involved—that not everyone will get everything they want.

Senator McCain's plan is far from perfect. In particular, his willingness to demonize sectors of the health care industry and to accept de facto price controls on prescription drugs is problematic. There is often a disconnect between his populist pretensions and his understanding of free markets that leads to an inconsistency between parts of his proposal. And it is possible to quibble even with some of the more market-oriented aspects of his plan (proposing a tax credit rather than a deduction, for instance).¹⁵⁸

Overall, however, he has the better proposal. Senator Obama's plan, with its heavy reliance on government, leads to the same problems that bedevil universal healthcare systems all over the world: limited patient choices and rationed care. McCain's proposal is much more consumer centered and taps into the best aspects of the free market.

As such it stands a reasonable chance of reducing health care costs. It won't achieve universal coverage, but it will likely increase the number of people with health insurance. And most importantly, it is far less likely than Senator Obama's proposal to do serious harm.

The results of McCain's and Obama's policies are likely to be very different for providers, patients, and taxpayers. As November approaches, voters will come to a fork in the road, and as Yogi Berra reputedly said, they'll take it.

Notes

1. Barack Obama, *The Audacity of Hope* (New York: Crown Publishing, 2007), pp. 22–23.
2. "Straight Talk on Health Care Reform," John McCain campaign, October 2007, <http://www.johnmccain.com/Informing/Issues/19ba2f1c-c03f-4ac2-8cd5-5cf2edb527cf.htm>.
3. "Kaiser Health Tracking Poll: Election 2008," Kaiser Family Foundation, March 2008.
4. "No Increase in Public Pressure for Healthcare Reform," Gallup Poll, November 29, 2007.
5. "'Access' Gains as Top Perceived U.S. Health Problem," Gallup Polls, December 3, 2007.

Both Obama and McCain tend to claim uncertain and unproven savings from painless steps such as preventive care and administrative simplification.

6. "No Increase in Public Pressure for Healthcare Reform." Interestingly, this criticism of the health care "system" comes even though Americans remain by and large satisfied with their own health care. Fully 88 percent of voters believe the quality of the care they receive is good or excellent, and 70 percent are satisfied with their insurance coverage. "Majority of Americans Satisfied with their Health-care Plans," Gallup Poll, November 29, 2007.
7. One might also ask about the Libertarian candidate, former representative Bob Barr. Although Barr can be presumed to support free market reforms for health care, his campaign website (www.bobbarr08.com) does not contain any information on the issue. Barr has released a You-Tube video in which he criticizes government interference in health care and calls for "restoring health care to doctors and the people." It does not, however, contain any specific proposals (see <http://www.youtube.com/watch?v=EpzSxciOl7o&feature=user>). While in Congress, Barr voted in favor of market-oriented reforms such as Health Savings Accounts. However, he also voted in favor of an early version of the Medicare prescription drug benefit, HR 4954, 2002. (Barr had left Congress by the time the final bill came to a vote.) Ramesh Ponnuru, "Bob Barr and Entitlements," *National Review Online*, May 13, 2008, <http://corner.nationalreview.com/post/?q=NjRjMmRhYTU1MzY4MzZiNWVjNWUyMjU4Zjk4ZGVhZjU=>.
8. Quoted in Karen Tumulty, "The Great Health Care Debate of 2008 is finally Engaged," *Time* Blog, April 30, 2008, http://www.time-blog.com/swampland/2008/04/the_great_health_care_debate_o.html.
9. Quoted in Larissa MacFarquhar, "The Conciliator," *New Yorker*, May 7, 2007.
10. See <http://iowa.barackobama.com/page/community/tag/Ames>.
11. See Alain Enthoven, "The History and Principles of Managed Competition," *Health Affairs* 12, Supplement 1 (1993): 24-48.
12. Hillary Clinton, "Remarks on American Health Choices Plan," Des Moines, Iowa, September 17, 2007.
13. Obama, *The Audacity of Hope*, p. 184.
14. *Ibid.*, p. 179.
15. *Ibid.*, p. 180.
16. Laura Meckler, "Clinton, Obama Split on Insurance Mandate," *Wall Street Journal*, February 23, 2008.
17. "Barack Obama's Plan for a Healthy America: Lowering Health Care Costs and Ensuring Affordable, High-Quality Health Care for All," Obama '08, www.BarackObama.com.
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