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AN ANALYSIS OF THE McCAIN HEALTH CARE PROPOSAL

Linda J. Blumberg and John Holahan

SUMMARY

OVERALL ASSESSMENT

The McCain health care plan represents a philosophical advance over many other health care proposals, principally in its commitment to redistributing the current tax exemption for employer-based health insurance. However, the plan raises more concerns than it addresses. The plan would

- provide a refundable tax credit that is more valuable to low-income workers than the current tax exemption for employer-based insurance, though the credit is not adequate to make coverage affordable for many;
- make insurance coverage less accessible and affordable for those with high health care needs;
- increase coverage among the currently uninsured through the nongroup market but reduce the number already covered by employers, leaving about the same number of people uninsured;
- have a high budget cost, at least in its early years.

In brief, McCain's proposal would dramatically change how many Americans obtain health insurance coverage, make coverage less accessible for those with health problems, have a high budget cost, but have little effect on the number uninsured.

Coverage

The proposed McCain tax credit would represent substantially greater subsidies for low-income people than have been available to date. However, the credit would not lead to significant net increases in insurance coverage:

- Tax credits would be the same size for all purchasers regardless of income. As a result, they would leave many low-income individuals with insufficient funds to afford adequate health insurance coverage.
- Affordability and accessibility of coverage would vary considerably by health status, age, and geographic area of residence.
- Health insurance policies would become less affordable over time because the value of the credit would increase with inflation, while the cost of health care has historically grown substantially faster.

Risk Pooling

By deregulating the health insurance market, the McCain plan would clearly decrease the sharing of health care risk. This would result in lower insurance costs for the young and healthy but would increase costs and decrease access for older individuals and those with health care problems.

- The new tax incentives would decrease employer-based coverage while increasing coverage in the nongroup market. Health insurance options in the nongroup market are often very limited for those with health problems.

- The provision to allow insurers to sell coverage to those residing anywhere in the country would undermine regulations that states have implemented to pool health care risk.

- These two provisions necessitate the reliance upon high risk pools as a fall-back mechanism to provide coverage to high-cost patients; however, McCain's proposed funding for these high risk pools falls far below what would be needed to make adequate coverage affordable to those patients.

Cost Containment

McCain's plan includes several features intended to contain costs.

- The proposal depends heavily upon tax incentives and an increased use of health savings accounts to contain rising health care costs. While these measures may create incentives to decrease spending, they will not have much effect on spending by sicker, high-cost people who account for a high percentage of the nation's spending.

- The plan proposes other strategies, such as the increased use of health information technology, chronic care management, and malpractice reform, but it is not clear if enough would be spent to successfully implement those strategies.

OUTSTANDING ISSUES

To address the problems with the proposal, the plan would need to

- provide a guaranteed source of adequate, affordable coverage for all individuals, regardless of health status;

- phase out the the employer exclusion over a period of years to avoid severe disruptions in health insurance markets;

- provide larger subsidies at the low end of the income distribution;

- develop a better strategy for spreading the costs of older and sick individuals broadly across the population; and

- make a significant commitment to cost-containment mechanisms to adopt efficient health information technology, strengthen prevention, evaluate the effectiveness of new technologies, and manage the costs of the chronically ill.

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An Analysis of the McCain Health Care Proposal

Linda J. Blumberg and John Holahan[1]

Senator John McCain has proposed a health care plan that would constitute a dramatic change in how insurance is purchased in the United States.[2] The approach would increase reliance on the private nongroup insurance market and would lead to decreased regulation of private insurance. While the plan would increase subsidization of low-income health insurance purchasers relative to today, the changes proposed carry substantial risks. This analysis delineates the central features of the McCain plan and describes their implications for affordability and coverage, the sharing of health care risk, and controlling the growth in medical spending. We also discuss the financing framework of the approach.

A key feature of the plan would *replace the current income tax exclusion* for employer contributions to health insurance with *refundable tax credits* for the purchase of health insurance, initially equal to $2,500 for individuals and $5,000 for families. The tax credits would apply regardless of whether the policy was purchased through the group market or purchased individually through the nongroup (direct purchase) market. The credit amounts would not vary with income or with the cost of coverage. In this way, the plan would redistribute a substantial amount of federal money to encourage the purchase of health insurance.

Another important feature of the McCain plan is that it would allow insurers to sell coverage to purchasers in any state. This would allow individuals and groups residing in states with greater insurance regulations to purchase policies from states with fewer regulations. In this way, the McCain approach would undermine state efforts to more broadly spread health care risks between the healthy and the less healthy. In lieu of insurance regulation, the McCain proposal would provide some federal funds (approximately $7 to $10 billion dollars a year) to support state high-risk pools.

Senator McCain relies primarily on the change in tax incentives to contain costs. Because the value of the new tax credits would be fixed and would grow slower than health care spending trends, he argues that people would have incentives to purchase lower-cost insurance plans than they do today. The theory holds that if individuals buy lower-cost plans with fewer benefits and higher cost-sharing requirements, they will be more cost conscious in the use of medical care. The plan's general approach to cost containment is to *decrease demand for health services at the individual level*; however, the proposal also has other cost-containment features. For example, McCain argues for malpractice reform, an emphasis on prevention and chronic care management, and the reimportation of low-cost pharmaceuticals from abroad.

The McCain proposal of redirecting the total amount of the current tax expenditure on employer-sponsored insurance toward health care reform would be an extremely large redistribution of federal dollars: the value of the current tax expenditure has been estimated to be as much as $200 billion in 2007.[3] Such a level of funding, appropriately targeted, could go a long way toward addressing the problem of the uninsured in the United States. Senator McCain deserves credit for the boldness of his approach and his willingness to redistribute federal dollars. However, we think that the proposal that he has laid out has serious problems with how those redistributed dollars would be targeted and how his approach would affect individuals with different levels of health care risk.

Stated simply, the McCain plan would (1) dramatically change the way Americans purchase health insurance; (2) incur a large budget cost, at

least in the early years; and (3) barely reduce the number of people that are uninsured.

Senator McCain's reliance on free-market principles and the increase in risk segmentation that would result from his approach would decrease access to insurance for those with higher-than-average medical needs and those at risk of higher medical costs due to their age or past health problems. The funds he devotes to high-risk pools, intended to address the drawbacks created as a byproduct of his reforms, would be far from sufficient to redress them. Because he would not provide greater subsidies to the low-income population than to the high-income population, the redistribution of current tax expenditures to providing refundable tax credits would not make coverage affordable for large numbers of the currently uninsured. In fact, it is possible that the combination of increased risk segmentation and limited financial assistance to the low-income population would lead to an *increase* in the number of uninsured. These issues are discussed in more detail below.

Coverage and Affordability

McCain's proposed tax credits are a significant improvement over the tax deductions that have been proposed by the Bush administration.[4] The fixed refundable tax credits suggested by McCain would have a greater dollar value for the low income than the tax deductions proposed in other reform packages, and they would make coverage more affordable for the low income as a consequence. Tax deductions suffer from the same failing as the current tax exemption for employer-based insurance: their value is greatest for those with the highest income, providing little if any value to those least able to afford to purchase private insurance on their own. However, by providing the same size tax credit to everyone, regardless of income, the redistributed tax subsidy still *would not* provide many low-income people with sufficient funds to afford an adequate health insurance benefit package.

Affordability of insurance under the McCain credits would vary considerably by health status, age, and geographic area of residence; plus, policies would get less and less affordable over time.[5] While a low-income, healthy young person living in a lower–health care cost state may be able to find an insurance policy in 2009 for $2,500 or even less, an older person, a person in less than perfect health, or someone living in a high–medical cost area will be *unlikely* to do so. For example, according to a survey by the Association of Health Insurance Plans (AHIP), the group that represents the nongroup insurers, the 2006–2007 average premium for a 60–64-year-old in the private nongroup market was $5,100[6] or, with inflation, roughly $5,700 in 2009; this is an average that reflects the healthier population with access to nongroup coverage. For a person living at the federal poverty level ($10,400 in 2008, likely about $10,800 in 2009), after the credit, paying the premium would require close to 30 percent of his or her income. And this does not even take into account the out-of-pocket costs associated with obtaining care with the typical nongroup policy; those plans tend to be substantially less comprehensive than those in the group market. Aside from higher deductibles and co-insurance levels, many of these policies either exclude or severely limit coverage of prescription drugs, mental health care, maternity care, and other services. Even if the credit were used in the employer-based market, today's average premium less the credit offered by McCain would still constitute close to 20 percent of the income of someone living at the poverty level.

The current tax subsidy could be redistributed in a more targeted fashion, however, either by expanding public insurance coverage for the lower income and/or by directing the great bulk of the tax credit subsidy dollars to those least able to afford private coverage on their own. Better targeting of the subsidies according to income would allow lower-income individuals to receive a larger credit, making coverage more affordable. Making the high-risk pools affordable would still require a great deal more government subsidy, however, since the average cost of coverage in those segregated pools would be far higher than those seen in today's nongroup markets.

In addition, the affordability problem under the McCain proposal would grow over time: the value of the tax credits offered would be indexed to the growth in the consumer price index (CPI), but per capita health care costs have consistently grown faster than CPI over time. The McCain plan assumes that people will spend less on

insurance if less is subsidized (and thus health care costs grow more slowly), but there is debate about whether this would happen (see below). Consequently, unless effective progress is made in containing health care costs or Congress increases the value of the tax credits as they fall farther behind growth in health care costs, the share of private insurance premiums for a given set of benefits covered by the credit would fall each year.

The Tax Policy Center projects that the McCain plan would reduce the uninsured by 1.3 million in 2009 and 4.6 million in 2013—a small fraction of the number uninsured (45 million were uninsured in 2007).[7] The modest net effects on the number of uninsured result from the fact that increased coverage due to the availability of tax credits would be offset by an erosion of employer-based coverage (see below).

The Sharing of Risk

The McCain approach has significant implications for how health care costs would be spread over individuals of different health status. We briefly review how risk is shared in health insurance in order to then clarify the implications of the senator's proposal. The central purpose of insurance is to pool risk, thereby protecting individuals from large financial losses and providing financial access to medical care when it is needed. Insurance regulations, primarily the responsibility of the states, are used to ensure the desired level of risk pooling. However, states vary in how heavily they regulate insurance in this regard. The more similar in health status the individuals in a particular insurance pool are, the less risk spreading takes place. Conversely, the more diverse the health status of the individuals in an insurance pool, the broader is the sharing of risk.

The greater the segmentation of health care risks, the lower are insurance costs for the young and healthy, while costs increase for the older and those with health care problems. Risk segmentation can be achieved by

- separating individuals of differing risks into different health insurance products;
- denying coverage outright to those at higher risk;
- limiting the benefits offered to higher-risk populations; or
- allowing price discrimination within the same products according to health status.

The financial burden of medical care can also be placed more heavily on higher users of care by increasing the share of medical costs paid out-of-pocket for services (e.g., higher deductibles, co-insurance, co-payments, or limiting or excluding insurance coverage for particular services). In this way, more of the costs of care are *taken out* of insurance premiums, shielding those who do not use care from more of the costs of those who do.

Greater segmentation, allowing low-risk individuals to avoid sharing in the cost of their higher-risk counterparts, makes medical care less accessible for many with serious health care needs, either because coverage is denied or the financial costs are too great. Broad risk pooling in voluntary health insurance markets brings its own complications: the healthy may choose to go without health insurance instead of paying premiums that are higher than their expected medical needs (due to the inclusion of less healthy people in the pools).

The McCain proposal would clearly increase risk segmentation. First, his approach would decrease coverage through employer-sponsored insurance, increasing incentives to purchase coverage through the private nongroup insurance market. Second, his proposal to allow sales of health insurance across state lines would undermine state health insurance regulations aimed at pooling health care risks. Third, these two provisions taken together force the McCain plan to rely upon high-risk pools as a fallback mechanism to provide coverage to many high-cost patients.

Decreasing Employer-Based Insurance Coverage

By eliminating the income tax exclusion for employer health insurance contributions and replacing it with a tax credit that retains the same value whether the coverage is purchased in the group or the nongroup markets, the proposed McCain reform would decrease current incentives to buy employer-based insurance. The current tax exemption for contributions to employer-

sponsored insurance is a primary reason individuals purchase insurance coverage through their employers. Those who take part of their compensation in health insurance contributions do not pay taxes on those contributions, as they would if that portion of their compensation was paid in wages. As a consequence, employers often use the provision of health insurance to attract workers they want. No tax subsidy for the purchase of private insurance exists outside the employment context, unless the individual is self-employed. As noted earlier, in aggregate, the forgone federal tax revenue amounts to over $200 billion, and approximately 60 percent of the nonelderly population receives health insurance through an employer (either their own or that of a spouse or parent). While the McCain plan would not subject employer contributions to payroll taxes, it would eliminate the largest part of the tax advantage for employer-sponsored insurance by subjecting the contributions to income tax and would likely decrease employer-based coverage significantly, particularly in small and medium-sized firms.

The structure of the current employer-sponsored insurance tax subsidy has been broadly and rightly criticized, by economists and policy analysts. The value of the subsidy is highest for those with the highest marginal tax rates—the high income—and provides the least value to those with low or no tax liability—the low income. Consequently, the subsidy is worth the most to those who are most likely to purchase health insurance even in the absence of any subsidy. The subsidy also increases in value with the level of health care spending, and therefore does not provide incentives to purchase coverage cost-consciously.

However, the subsidy has strongly encouraged group purchasing of coverage and employer groups provide natural risk pooling mechanisms. Premiums do not vary across workers in a single firm as a function of health status, and typical coverage is quite comprehensive. In addition, low-income workers employed in firms with substantial shares of higher-income workers often have access to comprehensive, employer-based insurance that is at least partially cross-subsidized by their higher-income counterparts. By eliminating the subsidy without providing alternative group purchasing options, the McCain proposal would leave many more individuals than today to purchase coverage in the nongroup market, a setting that does not generally serve the needs of those with significant health problems.

Private coverage purchased outside the employment context is usually considerably more complex and, in the vast majority of states, may not be available to all those wishing to purchase it, depending on their health status. Most states allow nongroup insurers to deny coverage outright and restrict particular benefits from the coverage offered based on health status: almost all states allow great premium pricing flexibility related to health status. In addition, coverage in the nongroup market tends to be considerably less comprehensive than coverage in the employer market, placing greater out-of-pocket costs on the users of medical care. In other words, with few exceptions, risk segmentation in the private nongroup market tends to be greater than in the employer-based market. Nongroup insurance, which accounts for a small fraction of coverage today, would serve as the central source for purchasing health insurance under the McCain approach.

The pull to the nongroup market would be particularly strong for those healthy and young workers currently purchasing coverage in firms with higher average medical costs. Plus, the smaller the employer, the lower are the administrative cost savings of purchasing coverage in the group setting relative to the nongroup setting, so coverage in small and medium-sized firms could be expected to decline the most.

The movement of younger and healthier workers out of the employer group market under the McCain plan would increase the average health care costs associated with individuals in the employer group market, since the remaining people would be more costly on average. This increasing average cost could create greater affordability problems in the group market for some and may lead to an upward spiral in group premiums. Increasing premiums may lead to fewer employers offering health insurance and fewer workers choosing to participate. Many of these workers may not take up coverage in the

nongroup market, potentially increasing the number of uninsured.

The premium cost for the same set of benefits is also higher in the nongroup market than in the group market because the administrative costs in nongroup constitute a substantially larger share of the premium than they do in the group market. Nongroup administrative costs amount to 35 to 40 percent of benefits, compared with less than 10 percent of benefits for the largest employer groups. The extensive underwriting processes, the marketing costs of selling coverage person by person, and the risk premiums that insurers add to protect themselves against the risk of attracting high-cost enrollees, all contribute to higher administrative loads.

Allowing Insurance to Be Sold across State Lines

Allowing private insurers to sell coverage across state lines in both group and nongroup markets is another central component of the McCain proposal. Senator McCain's intent seems to be to increase competition by increasing the number of policy options available to individuals purchasing coverage on their own. However, the most significant implication of such a reform would be to undermine state insurance regulations across the country.

States vary considerably in how much they regulate the pricing and selling of health insurance in their private markets. While federal law prohibits insurers from denying coverage outright to small firms, states are allowed flexibility in how much insurers can increase premiums for small firms with bad health experience and how much they can lower premiums for small firms with good health experience. In nongroup markets across the country, as discussed earlier, there is even more variation in regulations. Only a small number of states require insurers to issue policies to all applicants and prohibit price differences by health status. The other states permit the denial of coverage outright and vary considerably in how much they allow insurers to adjust premiums and offer different benefit packages to applicants according to a host of characteristics, including health status, age, and gender.

Under the McCain plan, a healthy person or a healthy small employer group in a state that limits variations in premiums based upon health status could find a lower premium by buying health insurance coverage through a state that does allow premiums to vary with health status. While this would create a financial advantage for the healthy, the average cost of buying coverage in the person's state of residence would likely rise dramatically over time, as only those who could *not* get cheaper coverage due to their good health would remain in that market. The end result of such a dynamic could quite plausibly be that all states would discontinue regulations of health insurance that were designed to pool risk across individuals of different health statuses.

Such an outcome would lead to many more people with health problems unable to purchase private coverage *at any price*, as states would have to allow insurers to deny coverage outright in the nongroup market or else they would attract only the bad insurance risks in the state. The typical coverage would become less comprehensive as well, with benefit exclusions and limitations becoming the norm across the country. State regulatory environments would become a race to the bottom, since no insurer would be able to compete by pooling risk broadly if those whose health care risk was better than the average in their state pool could get a better deal elsewhere. This dynamic would also be expected to lead to the elimination of many, if not all, state benefit mandates.[8]

Increased Funding for High Risk Pools

The McCain proposal attempts to mitigate the increase in risk segmentation by subsidizing state high-risk pools for those unable to obtain health insurance coverage in private markets. The proposal would spend $7 to $10 billion in federal funds a year on expanding state high risk pools. However, this level of funding is insufficient to ensure affordable access to adequate coverage for all those who would be disadvantaged by the McCain approach.

First, while most states have high-risk pools, about a third do not. The McCain proposal does not require states without one to create one, nor does it require the federal government to provide a pool if a state does not have one. Second, the level of funding is inadequate. Because the distribution of health care costs is highly skewed, the vast majority of health care expenditures are

attributable to a small share of the population. For example, the top 10 percent of spenders account for 64 percent of total health expenditures (64 percent of private insurance premium and out-of-pocket payments were $543 billion in 2006),[9] and the top 25 percent of spenders account for 85 percent.[10] By segregating many of these individuals into separate risk pools, there would be no healthy individuals with whom to average their costs. And while some high-cost patients would likely remain in employer-based insurance through large employers, the magnitude of the costs incurred by the high-need segment of the population means that making adequate coverage affordable would require very large subsidies.

According to the AHIP study referenced earlier, in 2006/2007 11 percent of nongroup applicants were denied coverage outright, 10 percent were offered a plan at a premium rate above standard levels, and 7 percent were offered coverage that permanently excluded specific conditions. Taken together, 28 percent of applicants were either denied coverage completely or were made a substandard offer. The increased size of the population shopping for coverage in the private nongroup market, the significant percentage of applicants likely to be denied or unable to find adequate affordable coverage in that market, and the large share of health expenditures attributable to them suggests that individuals eligible for high-risk pools under a McCain approach might well account for a large share of total national personal health care expenditures.

Under this scenario, $7 to $10 billion a year would barely make a dent in the financing needed to provide adequate, affordable coverage to the eligible population, especially combined with the expected decline in employer-based insurance coverage that would result from the tax changes that are part of this reform package. Even if only half of those in the top 10 percent of spenders enrolled in the high-risk pools, and they paid part of the costs themselves based on their ability to pay, the costs could conservatively run *well over $100 billion a year*.[11] Without much greater financing than the McCain plain suggests, high-risk pool coverage would have to be severely limited, leaving many higher-need persons without access to coverage or affordable care.

Cost-Containment

Senator McCain relies heavily on the change in tax incentives described above and expansions of health savings accounts (HSAs) to contain costs. He argues that if individuals face higher out-of-pocket premiums and cost sharing, they will decrease their demand for medical care and, in response, delivery systems will reorganize to become more efficient. His theory assumes that, faced with costs more directly, people will shop for lower-cost care and will reduce their use of unnecessary services.

However, such changes are not likely to decrease aggregate health care spending as intended. First, research evidence strongly indicates that as cost sharing increases, individuals decrease the number of initial contacts with providers but do not spend less once they begin to receive care.[12] This means that individuals faced with higher out-of-pocket costs decide, without professional advice, to eliminate encounters with health care professionals. And since individuals are not particularly adept at discriminating between necessary and unnecessary care, they decrease their use of both, which can adversely affect their health. In an ideal situation, cost-containment strategies would provide incentives for individuals to use care more efficiently. It is possible that McCain's proposed tax incentives could increase both the purchase of health insurance plans that employ aggressive managed care techniques and policies with higher deductibles and more limited benefits. Aggressive managed care plans might become better at encouraging more cost-effective treatment regimes, but these approaches have proven unpopular with consumers.[13]

Second, as noted earlier, the bulk of national health care spending is attributable to a small share of the population. The vast majority of health care spending is accounted for by very sick or seriously injured individuals whose spending exceeds even the high deductibles set for HSA-compatible plans.[14] Once the deductible has been met on these plans, no new incentive exists for these high spenders to contain their costs. Without reforms that identify and implement mechanisms for creating efficiencies in the care delivered to high-cost populations, significant cost containment cannot be achieved.

The McCain proposal does have some other cost-containment features. For example, he proposes bundling payments to providers in circumstances where multiple providers contribute to the treatment of a particular illness. Under such a policy, a single total payment would be made for a course of treatment and the providers would negotiate among themselves how that payment would be distributed. The argument is that this approach would lead to reduced overall spending because it would provide incentives for providers to become more efficient and would make pricing more transparent to patients. However, as Ginsburg has described, it is easy to overstate the potential for bundled pricing to contain health care costs.[15] Most services do not lend themselves easily to bundling or to straightforward price comparisons.

Other cost-containment strategies proposed by the McCain campaign include improving the management for chronic disease, expanding the use of health information technology, increasing identification and adoption of best practices, reforming malpractice legislation, and encouraging smoking cessation programs. All these have some potential to reduce health spending if they are aggressively pursued, although by a relatively small amount in each case.[16] The evidence on prevention is mixed; it could have some potential for reducing obesity.[17] We see clear potential for cost savings in the treatment of chronic disease, particularly in reducing unnecessary hospitalizations, through programs that fully involve physicians in care management.[18] The potential for savings exists through accelerating the use of health information technology, by reducing both office expenses and unnecessary services—for example, duplicative testing.[19] But adoption of health information technology is also expensive for providers to implement. If electronic health records reach their potential, providers would likely see lower revenues because of fewer unnecessary tests and hospitalizations, potentially making them resistant to investing in and adopting the new information technology. Several of these approaches can save money but they will face resistance from affected providers and will need to be aggressively pursued. The McCain plan seems to devote fewer resources to these initiatives than does the Obama plan.[20]

Financing

The McCain plan is designed so his proposed tax credits would exceed the value of the current exemption in the early years of the plan. But since the credits would grow with increases in inflation while the tax exemption of employer contributions would grow with health care costs, the cost to the government would decline over time.

The Tax Policy Center has estimated that the McCain plan would cost $185 billion in 2009, $141 billion in 2013, and would continue to decline each year thereafter.[21] Thus, while the first year costs are roughly double that of the Obama plan, over a 10-year window, spending would be about 20 percent less. However, the Tax Policy Center could not model the costs of the high-risk pool. If the high-risk pool were to adequately address the cost of sicker individuals who would be excluded from nongroup plans, the plan would cost substantially more. As noted earlier, depending on the structure of the plan, including how it is subsidized, the high-risk pool could easily cost well over $100 billion annually.

In general, lower-income people with health insurance would receive benefits from the credit that would be well in excess of the value that they receive from today's tax exemption. The gains are much smaller for higher-income people. Even still, these credits would have to be increased for low-income people if coverage is to be made widely affordable. If the credits were increased for the low income, the value of the credit could be phased out as incomes increase to keep the budget consistent with the original proposal. However, such a change to the McCain proposal would lead to a substantial increase in taxes for the high income, due to the loss of the current law tax exclusion and the credit phase-out as incomes increase.

The McCain plan also assumes the tax credit would grow with inflation. The theory is that having individuals paying more at the margin for health insurance would lead to the purchase of less costly insurance and that this, in turn, would slow the growth rate of health care costs. To the extent that the expected impact on cost growth

does not materialize and premium and out-of-pocket medical expenses grow relative to the tax credit, substantial political pressure to increase the value of the tax credits may develop. It this was the case, it would offset some of the longer-term budget savings that are currently envisioned under the plan. If the cost- containment measures are successful at lowering health care spending in every sector, however, some other federal and state government savings could result via reductions in Medicaid and Medicare expenditures.

Conclusion

The McCain proposal represents a philosophical advance over many other health care proposals, principally in its commitment to redistributing the current tax exemption for employer-based health insurance. But it raises more concerns than it addresses. Several changes would probably be necessary for it to receive bipartisan support.

First, the plan needs to provide a guaranteed source of adequate affordable coverage for all individuals, regardless of health status. This can be accomplished by creating new purchasing pools or by opening existing public programs or state or federal employee health plans to all applicants. The credit could then be made available only for employer-based insurance or other insurance that meets such standards as guaranteed issue, community rating, maximum out-of-pocket liabilities, and minimum benefit levels.

Second, the exclusion of employer contributions should be phased out slowly over a period of years to allow individuals to gravitate into the new insurance options without creating abrupt disruptions in the coverage that most Americans have today.

Third, the proposal needs to provide larger subsidies at the low end of the income distribution, either through public program expansions or income-related subsidies that are more generous than the proposed flat tax credits.

Fourth, the plan needs to embrace strategies for spreading the costs of older and sicker individuals broadly across the population, especially because there is no mandate that individuals obtain health insurance coverage. Regulation of premiums across all sources of insurance or explicit subsidization for those with high costs could help accomplish this. If the development of broad-based health care risk pools is not part of the approach, then an exceedingly large commitment of government resources would be necessary to address the needs of this population.

Finally, the plan needs a strong commitment to cost-containment mechanisms beyond the market-based approaches at the heart of the proposal—that is, adopting health information technology, strengthening prevention (e.g., obesity, smoking, and diabetes), evaluating the effectiveness of new technologies, and managing the cost of the chronically ill.

Notes

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[2] "Straight Talk on Health System Reform," http://www.johnmccain.com/Informing/Issues/19ba2f1c-c03f-4ac2-8cd5-5cf2edb527cf.htm (accessed 22 September 2008), "2008 Presidential Candidate Health Care Proposals: Side-by-Side Summary," 22 July 2008, http://www.health08.org/sidebyside.cfm (accessed 18 September 2008).

[3] Len Burman, Testimony before the US Congress House Committee on the Budget, "Hearing on the Tax Code and Health Insurance Coverage," October 18, 2007.

[4] U.S. Department of Treasury, *General Explanations of the Administration's Fiscal Year 2008 Revenue Proposals,* 2007. http://www.treas.gov/offices/tax-policy/library/bluebk07.pdf, accessed September 17, 2008.

[5] Subsidizing coverage through a tax credit, regardless of the size of the credit, makes it very difficult to address the geographic variations in medical costs. It is not clear if it is feasible to have a federal tax whose value varies by area of residence. A subsidy that limits health care costs as a percentage of income is, however, a mechanism for addressing such geographic variations in affordability.

[6] AHIP Center for Policy Research. "Individual Health Insurance 2006-2007: A Comprehensive Survey of Premiums, Availability, and Benefits." http://www.ahipresearch.org/pdfs/Individual_Market_Survey_December_2007.pdf, accessed September 20, 2008.

[7] L. Burman, S Khitatrakun, et al., 2008. "An Updated Analysis of the 2008 Presidential Candidates' Tax Plans," Tax Policy Center Report, September 12, http://www.taxpolicycenter.org/publications/url.cfm?ID=411749, accessed September 18, 2008.

[8] Consumer protections would also likely be at greater risk in a scenario with cross-state sales of insurance coverage. States would be responsible for oversight of insurance sold by insurers in their state, but they would not be responsible for overseeing coverage sold to its residents from outside the state. It is unclear whether states will enforce consumer protections for residents of other states.

[9] Aaron Catlin, et al., "National Health Spending in 2006: A Year of Change for Prescription Drugs," *Health Affairs* 27, no. 1 (2008): 14–29.

[10] Samuel H. Zuvekas and Joel W. Cohen, "Prescription Drugs and the Changing Concentration of Health Care Expenditures," *Health Affairs* 26, no. 1 (2007): 249–57.

[11] Authors' calculations inflating the Zuvekas and Cohen (2007) estimate of average health care spending for those in the top 10 percent of spenders in 2003.

[12] Michael E. Chernew, Testimony before the Subcommittee on Health of the House Committee on Ways and Means, May 14, 2008. http://waysandmeans.house.gov/hearings.asp?formmode=view&id=6915, accessed June 23, 2008.

[13] In addition, large differences in actuarial value of available plans (high cost sharing, limited benefits versus more comprehensive but tightly controlled managed care plans) will tend to attract purchasers of different health care risks, leading to additional segmentation.

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