Bush *and* Kerry Health Care Proposals: Cost *and* Coverage Compared

SEPTEMBER 21, 2004

The Lewin Group

PREFACE

Next year marks The Lewin Group's 35th anniversary. The firm has a long history of providing objective, independent health care and human services policy analysis and consulting. Earlier this year, we decided to conduct an independent analysis of the major 2004 Presidential candidates' health care plans. We notified each campaign that we were producing nonpartisan comparative analyses of the proposed plans of President George W. Bush and Senator John F. Kerry. In developing our estimates, we used publicly available information on plan specifications and information received from the campaigns as of September 15, 2004.

The Lewin Group has considerable experience in analyzing the impact of health reform initiatives on major stakeholder groups, including employers, providers, governments and consumers. Lewin analyses primarily are based upon a model of the US health care system called the Health Benefits Simulation Model (HBSM), which has been continually refined since 1989, when it was used to estimate the cost of alternative universal coverage proposals for the Bipartisan Congressional Commission on Health Care. Since then, the model has been used to analyze a broad range of health reform proposals at the state and federal levels. A detailed description of HBSM is available.

The Lewin Group recently completed a comparative analysis of 10 major health reform proposals developed by prominent health policy experts for the "Covering America" project sponsored by the Robert Wood Johnson Foundation (RWJF). Prior to this, Lewin performed a comparative analysis of 8 health reform proposals developed by major stakeholder groups for the "Coverage 2000" project, also sponsored by RWJF. The model also has been used to study health reform proposals introduced at the state level, including several State Planning Grant projects funded by the US Health Resources and Services Administration (HRSA). In conducting these studies, we have developed extensive experience in taking health care proposals, which typically are not thoroughly detailed in their specifications, and producing complete and coherent impact estimates.

This analysis was directed by Mr. John Sheils, a Vice President with The Lewin Group, who is a nationally known expert on designing and evaluating health coverage reform proposals. Mr. Sheils joined Lewin in 1980 and has established the firm as one of the leading independent sources of information and analysis on the financial impacts of major health reform initiatives. He has testified before congressional committees and often works directly with members of Congress in evaluating and developing health reform initiatives.

Mr. Sheils was assisted by Mr. Randall Haught, a Senior Scientist. Mr. Haught has worked for over a decade with Mr. Sheils in the development and refinement of HBSM. He has extensive experience in estimating the impacts of health reform initiatives on health spending.

The study and the appendices also are available on The Lewin Group's Website at www.lewin.com.

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EXECUTIVE SUMMARY

The Lewin Group, a nonpartisan health care and human services research and consulting firm, has prepared an objective appraisal of the health care plans put forth by this year's two major party presidential candidates, President George W. Bush and Senator John F. Kerry. We assessed each proposal using a well-vetted proprietary model, the Health Benefits Simulation Model (HBSM). Our analysis focused on two key questions:

1) How many people who currently lack health insurance would become covered under each candidate's program?
2) How much money would each program cost the federal and state governments, consumers and other financial contributors over the 10-year span following implementation in 2006?

Our analysis makes no judgment as to which candidate's plan is better. We simply supply a detailed breakdown of the effects of the two plans, giving information to allow each reader to come to his or her own conclusion.

Summary of the Candidates' Plans

Measures to Broaden Health Insurance Coverage

Central to both candidates' plans is the expansion of coverage for people currently lacking health insurance. The two plans differ in their scope. The Bush plan emphasizes expanded private sector insurance supported by tax incentives. The Kerry plan mixes private sector reforms, together with expansions in enrollment in Medicaid, the State Children's Health Insurance Program (SCHIP) and the Federal Employees Health Benefits Program (FEHBP).

The Bush plan seeks to broaden private insurance coverage by offering tax relief. It would award individuals who set up Health Savings Accounts (HSAs) a tax deduction for the premiums they pay for low-cost, high-deductible health insurance policies and grant tax credits to small employers that set up and contribute to HSAs for their employees. Bush also proposes tax credits for individual health insurance and a tax deduction for individuals who buy long-term care insurance, as well as an additional personal exemption to home caregivers of ailing family members.

In addition, Bush's plan would allow small businesses to form Association Health Plans (AHPs) to gain greater purchasing power in the insurance market. AHPs also would be exempt from state benefits mandates and state solvency rules, as large self-insured employers are today.

The Kerry plan would use existing federal programs to extend health insurance coverage. First, the federal government would pay the full costs of 20 million children in Medicaid, in exchange for states expanding coverage to children in families with incomes above the current Medicaid and SCHIP income thresholds as well as to low-income adults. Second, Kerry would create the Congressional Health Plan, a pool within the FEHBP, to offer insurance to individuals and to small employers. Third, the Kerry plan would have the federal government "rebate" three-fourths of employers' catastrophic health claims costs (above $30,000 per beneficiary in 2006).

The Kerry plan also would target tax credits for health care costs to people whose incomes fall below 300% of the Federal Poverty Level (FPL). Finally, Kerry includes a tax credit of up to 50% of costs of employee premiums to expand coverage for small businesses that cover "low- and moderate-income" employees.

Added Health Reform Measures

Each proposal contains an assortment of other measures generally aimed at making health care more affordable and/or at making patients' experiences with the health system more favorable. Key provisions are as follows:

Medical Malpractice

Both plans speak to the need for medical malpractice reform. The Bush plan proposes adopting national standards designed to rein in high damage awards, while the Kerry plan focuses on eliminating frivolous lawsuits.

Health Information Technology (HIT)

Both candidates propose increasing the focus on HIT, and they share the goal of widespread adoption of electronic medical records. Their methods and time frames differ somewhat.

Prescription Drug Costs

The Bush plan does not address prescription drugs beyond what already has been enacted through the Medicare Prescription Drug, Improvement and Modernization Act of 2003. The Kerry plan promotes plans to allow reimportation of drugs subject to safety certification, to accelerate entrance of generic drugs to market, to require pharmacy benefit management firms to disclose more financial information and to empower both the federal government and the states to negotiate more aggressively for drug price discounts.

Disease Management

The Bush plan does not address disease management explicitly. The Kerry plan expects employers to work with insurers or others offering disease management as a condition of accessing the newly proposed federal premium rebate for catastrophic costs. There also are unspecified financial incentives to providers that perform disease management.

Quality Improvement and Reduction of Medical Errors

President Bush promotes a new voluntary medical error reporting system and supports the creation of patient safety organizations. Senator Kerry's plan offers financial incentives to encourage providers and purchasers to improve quality.

Patient's Rights

The Bush plan offers provisions designed to broaden access to specialty and emergency care. The Kerry plan proposes a patient's bill of rights that speaks to access to specialty care and emergency care, opportunities to appeal adverse insurer determinations, the right to sue HMOs and whistleblower protections.

Key Findings

Figure ES-1 displays the study's key findings for each candidate's plan. These findings relate to reductions in the uninsured and net changes in employer coverage, net changes in federal and state expenditures and changes in insurance and family spending. The remainder of this executive summary highlights the impact of these findings.

Figure ES-1:
Key Findings of the Candidates' Plans

	The Bush Plan	The Kerry Plan
Reduction in Uninsured (2006)	8.2 million	25.2 million
Percent Reduction in Uninsured (2006)	17%	51%
Percent of Population Covered (2006)	86%	92%
Net Change in People with Employer Coverage (2006)	(1.2 million)	2.1 million
Change in Total Federal Expenditures (2006-2015)	$227.5 billion	$1,249.0 billion
Change in Total State Expenditures (2006-2015)	($19.9 billion)	($343.5 billion)
Changes in Employer Health Spending (2006)	($4.7 billion)	($52.1 billion)
Changes in Private Insurance Market Premiums(2006-2015)	$9.9 billion	($773.9 billion)
Net Change in Yearly Average Family Health Care Spending (with plans unfunded by any tax changes) (2006)	$68 per family	($451) per family

Numbers in parentheses reflect savings or reductions.
Source: The Lewin Group estimates.

Reductions in the Number of Uninsured People

Our analysis assumes that either candidate's proposed reforms would be enacted during 2005 and would take effect in 2006. By 2006, absent intervention, we project that the number of Americans lacking health insurance coverage will rise to 49.5 million, or 17.1% of the nation's total population of 289.1 million.

Given this baseline number of uninsured, our analysis of the competing plans reveals these changes in the number of people having health insurance (***Figure ES-2)***.

Figure ES-2:
Changes in Uninsured Population Under the Candidates' Plans: 2006[a/]

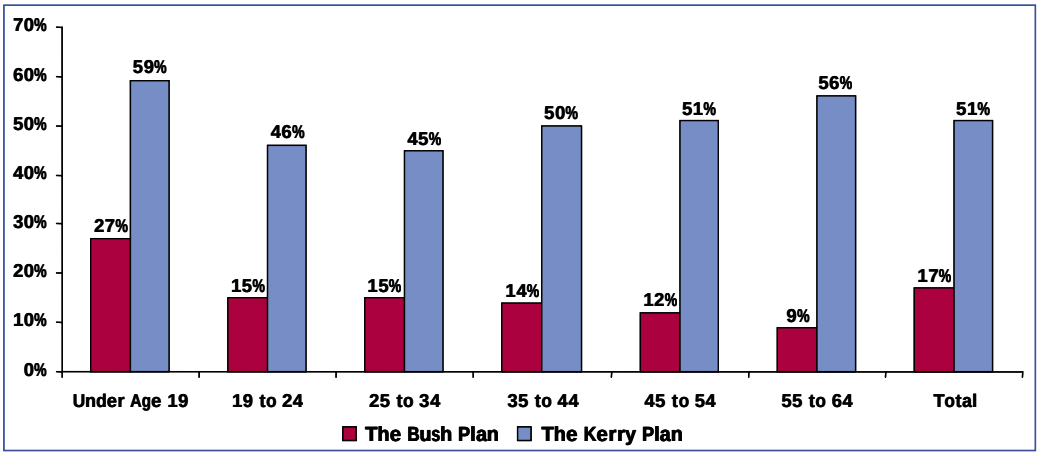
	The Bush Plan	The Kerry Plan
Number Uninsured Before Reform	49.5 million	49.5 million
Number of People Newly Covered	8.2 million	25.2 million
Number Uninsured After Reform	41.3 million	24.3 million
Uninsured Percentage After Reform	14%	8%

a/ Assuming both plans are implemented in 2006.
Source: The Lewin Group estimates.

Different subsets of the uninsured population become covered under each plan. Looking at the age distribution, both plans have the greatest impact on children under age 19, with Bush's plan covering 27% of the uninsured in that age group and Kerry's covering 59%. The Bush plan's coverage effects decline steadily as people get older, with 9% of the uninsured in the 55 to 64 age range becoming covered. The Kerry plan's coverage benefits do fall off slightly for the 19 to

24 and 25 to 34 age groups, but then climb for older adults, reaching 56% in the 55 to 64 age category (***Figure ES-3***).

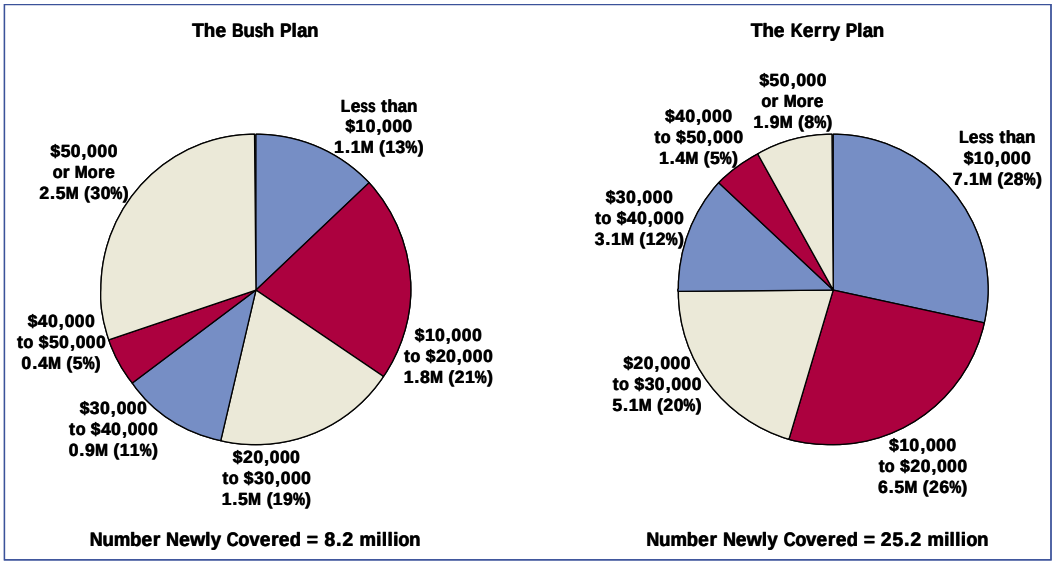
Figure ES-3:
Percent of Uninsured Covered Under the Candidates' Plans by Age: 2006[a/]



a/ Assuming both plans are implemented in 2006.
Source: The Lewin Group estimates.

Looking at the distribution of new coverage across income groups, the Bush plan's effects are more dispersed; 53% of those newly insured under the Bush plan have family incomes of $30,000 or less and 30% have incomes of $50,000 or more. The Kerry plan's effects are strongest at the lowest end of the income scale and then decline as incomes rise; 74% of the newly covered have incomes of $30,000 or less and 8% have incomes of more than $50,000. These effects are shown in the chart below (***Figure ES-4***).

Figure ES-4:
Distribution of Uninsured Covered Under the Candidates' Plans by Family Income: 2006[a/]



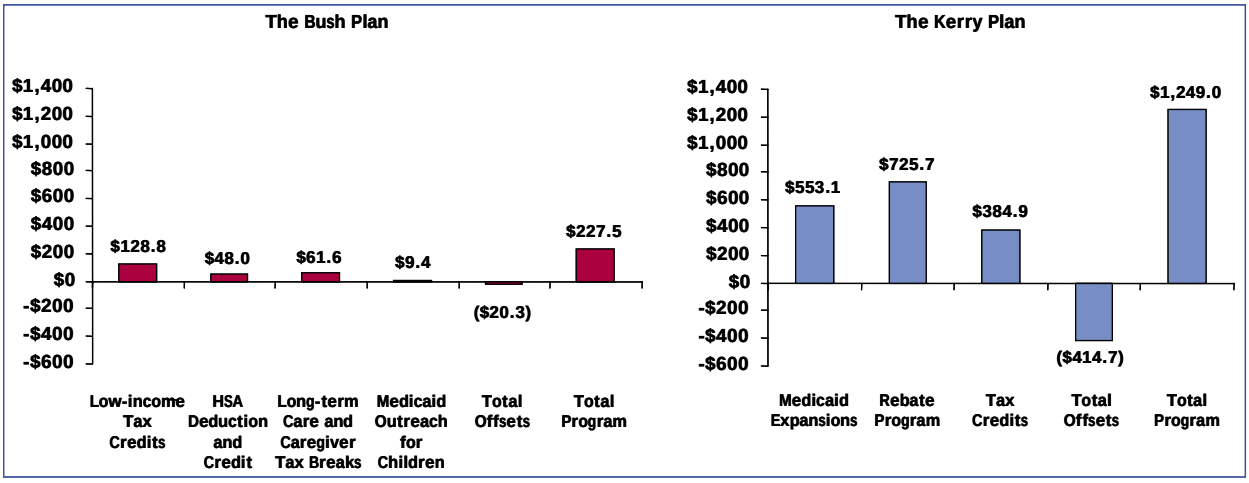
May not sum to totals due to rounding.
a/ Assuming both plans are implemented in 2006.
Source: The Lewin Group estimates.

Cost Implications for Government, Employers and Consumers

Our analysis reveals very different cost effects for the federal government, state and local governments, private insurers, employers and consumers. In general, the Kerry plan, due to its expansion of Medicaid to increase coverage, has the federal government taking on a much larger share of the nation's health care costs and, in turn, creating substantial savings for all other contributors. The Bush plan's effects generally move in the same direction, but are less pronounced than the Kerry plan.

The charts below show federal, state and local expenditure components and their respective totals (***Figures ES-5*** and ***ES-6***).

Figure ES-5:
Total Federal Health Spending for the Candidates' Plans Compared: 2006 – 2015
(in billions)

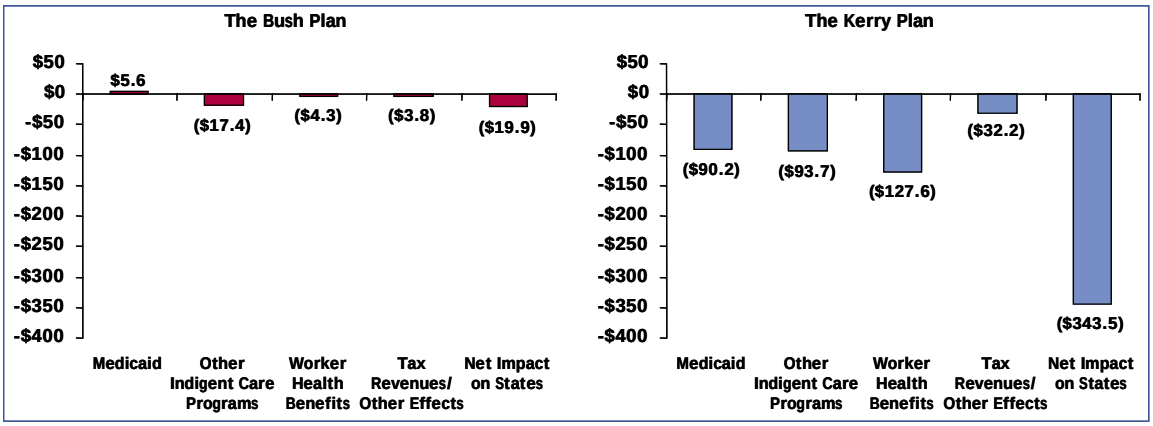


May not sum to totals due to rounding.
Numbers in parentheses reflect savings.
Source: The Lewin Group estimates.

The Bush plan would elevate federal spending by about $227.5 billion over the 2006 through 2015 period. This includes $128.8 billion in tax credits to low-income people and about $42.8 billion in HSA tax deductions. The small employer tax credit for HSAs would cost about $5.2 billion, and federal Medicaid spending would increase under the outreach program by about $9.4 billion. In addition, the Bush plan has about $61.6 billion in tax deductions for long-term care insurance and the home caregiver exemption. There would be offsets of about $20.3 billion.

The Kerry plan would add about $1,249.0 billion to federal spending over the 10-year period. The Medicaid expansion, with the federal government taking on the full cost of Medicaid for 20 million children and sharing in various coverage expansions, would increase federal costs by $553.1 billion. Catastrophic stop-loss protection for private employer plans (characterized in the Kerry plan as a "rebate" program) would cost $725.7 billion, and the tax credits for low- and moderate-income people would be $384.9 billion. Offsets to federal costs amount to $414.7 billion, mostly in the form of higher tax revenues thanks to reductions in employer health costs resulting from the small employer tax credit and the reinsurance program.

Figure ES-6:
Summary Comparison of Candidates' Plans
State and Local Government Spending: 2006 – 2015
(in billions)



May not sum to totals due to rounding.
Numbers in parentheses reflect savings.
Source: The Lewin Group estimates.

Both candidates' plans would produce savings for state and local governments, largely due to a reduction in spending under their indigent care programs. Under the Bush plan, state and local government spending would fall by $19.9 billion over the 2006 through 2015 period, while under the Kerry plan, spending would decline by $343.5 billion. The single largest source of savings for states and localities ($207.4 billion) comes from Kerry's plan to have the federal government pay the full Medicaid cost for 20 million children (***Figure ES-6***).

Private insurance plan premiums would rise by $9.9 billion over the 10 years under the Bush plan (***Figure ES-7***). This effect mainly stems from the enhancement of patients' access to emergency and specialty services. Under the Kerry plan, private insurance premiums would fall by an aggregate 10-year total of $773.9 billion. This large reduction primarily is driven by Kerry's plan to have the federal government cover a share of high-cost claims for most private health insurance plans.

Figure ES-7:
Changes in Private Insurance Market Affecting Premiums
Under the Candidates' Plans: 2006 – 2015
(in billions)

	The Bush Plan	The Kerry Plan
Medical Malpractice Reform	($26.8)	($7.0)
Patient's Bill of Rights	$62.3	$108.9
Reduced Cost-shifting	($12.6)	($95.0)
Association Health Plans	($13.0)	--
Rx Drug Provisions	--	($21.7)
Administrative Simplification	--	($17.9)
Disease Management	--	($15.5)
Premium Rebate	--	($725.7)
Net Change in Spending	$9.9	($773.9)

Columns may not sum to totals due to rounding.
Numbers in parentheses reflect savings.
Source: The Lewin Group estimates.

Beyond the premium effects just described, employers would realize savings through factors such as tax credits under both plans. Some employers also would see savings under the Kerry plan, as employees cease to be covered by private insurance when they pick up Medicaid or other newly expanded state coverage.

Consumer out-of-pocket spending for health care—comprised of both contributions toward health insurance premiums and out-of-pocket costs for deductibles, co-payments and noncovered items—would be affected under both plans. The Bush plan would increase average family health spending by about $68 per year. The Kerry plan would reduce average family health spending by about $451 per year. These estimates assume no change in taxes to pay for these proposals, effectively adding to the federal deficit. If taxes were increased to pay for the proposals, the impact on families would differ markedly.

The Bush and Kerry health care plans present different approaches to expand health insurance coverage, to make health care more affordable and to improve patients' experiences with the health system. As the analysis demonstrates, the candidates' plans vary in their effects on who is covered; the mechanisms to support affordable health insurance; and in the costs for the federal government, state and local governments, private insurers, employers and consumers.

BUSH AND KERRY HEALTH CARE PROPOSALS: COST AND COVERAGE COMPARED

Introduction

This study provides estimates of the cost and coverage impacts of the health care plans introduced by President Bush and Senator Kerry in the 2004 presidential campaign. Both candidates propose policies to expand health insurance coverage to some of the 45 million Americans who lack such coverage today. The plans include provisions that are designed to help reduce the cost of private health insurance, which is expected to result in more people taking private coverage, as well as other provisions to improve the health care system.

President Bush and Senator Kerry take decidedly different approaches to expanding health insurance coverage. The Bush plan relies on broadening the private insurance market with the addition of tax credits and deductions. The Kerry plan also provides tax credits to small businesses, but adds a major expansion in eligibility for low-income people under Medicaid.

The Bush plan would create refundable tax credits for the purchase of health insurance or a Health Savings Account (HSA) for low- and middle-income families who do not have employer coverage, and it would provide a tax deduction for the purchase of HSAs. The Bush plan also would create a small business tax credit for providing HSAs to their workforce. The Bush plan would permit the creation of Association Health Plans (AHPs) that are exempt from state mandated benefits laws, to give small employers greater freedom to define their benefits packages. The Bush plan includes an outreach program to enroll children who already are eligible for Medicaid or the States Children's Health Insurance Program (SCHIP). The Bush plan also includes several reforms of medical malpractice, including limits on awards.

The Kerry plan proposes to expand health care coverage in several ways, with the goal of insuring 95% of the population. The Kerry plan would reduce the cost of private insurance to employers and individuals by covering high-cost beneficiaries under a federal "reinsurance program." The Kerry plan would expand Medicaid and SCHIP, in exchange for states expanding coverage to children in families with higher incomes as well as to low-income adults with an enhanced federal match rate, and it would offer states enrollment bonus incentives to enroll eligible children.

The Kerry plan would establish the Congressional Health Plan (CHP), a pool within the FEHBP, to offer insurance to small employers and individuals so long as employers pay at least 50% of the employees' premiums, with subsidies to low- and moderate-income people. The plan also proposes a number of tax credits for individuals, including a tax credit of up to 50% of costs of employee premiums to expand coverage for small businesses that cover low- and moderate-income employees. The Kerry plan also promotes the use of disease management and simplified health plan administration.

We estimated the impact of the Bush and Kerry plans using the Health Benefits Simulation Model (HBSM) developed by The Lewin Group. We used uniform data and assumptions for both plans, to assure that differences in estimated plan impacts are attributed to differences in

program design rather than mere inconsistencies in assumptions. ***Appendix B*** describes the assumptions and methods used to estimate their impacts. A detailed documentation of HBSM is available upon request.

We used HBSM to estimate the impact of the candidates' plans on the number of people with insurance coverage and the cost impacts for major stakeholder groups. In the following sections, we summarize the details of these plans and present our estimates of the number of people likely to take insurance coverage under each plan. We also present estimates of costs for the federal government, state and local governments, employers and consumers.

Wherever possible, we based our specifications of the candidates' plans on written materials released by the administration and the candidates' Internet sites. However, both plans include areas where it is unclear how certain aspects of their proposed programs would operate. Where details are lacking, we specified our assumptions on how these programs might operate, in order to illustrate the potential impacts of these plans. A detailed analysis of the various provisions of these plans is presented in ***Appendices A, C*** and ***D***.

Results are presented in the following sections:

Changes in sources of insurance coverage;
Federal spending and revenues;
State government spending and revenues;
Impact on private insurance market;
Employer costs;
Impacts on consumers;
Electronic medical records (EMRs); and
Caveats.

I. Changes in Sources of Coverage

We estimate that there will be an average of about 49.5 million people without insurance at any point in time during 2006 (***Figure 1***).[1] The Bush plan would reduce the number of uninsured by about 8.2 million people. This reflects the impact of the tax credits, the deduction for HSA coverage, the small business tax credit and the outreach program to enroll children eligible for Medicaid and SCHIP.

The Kerry plan would reduce the number of uninsured by about 25.2 million people. Most of this would be due to the expansions in eligibility for Medicaid under the plan. Employer coverage would increase by about 2.1 million people, largely due to the small employer tax credit and rebate program. The number of people with non-group coverage would increase by 1.5 million people, due to the tax credits for non-group coverage under the Kerry plan.

[1] This is based upon the 1999-2001 MEPS data updated to reflect population growth. We estimate that there are about 34.7 million people uninsured for the entire year.

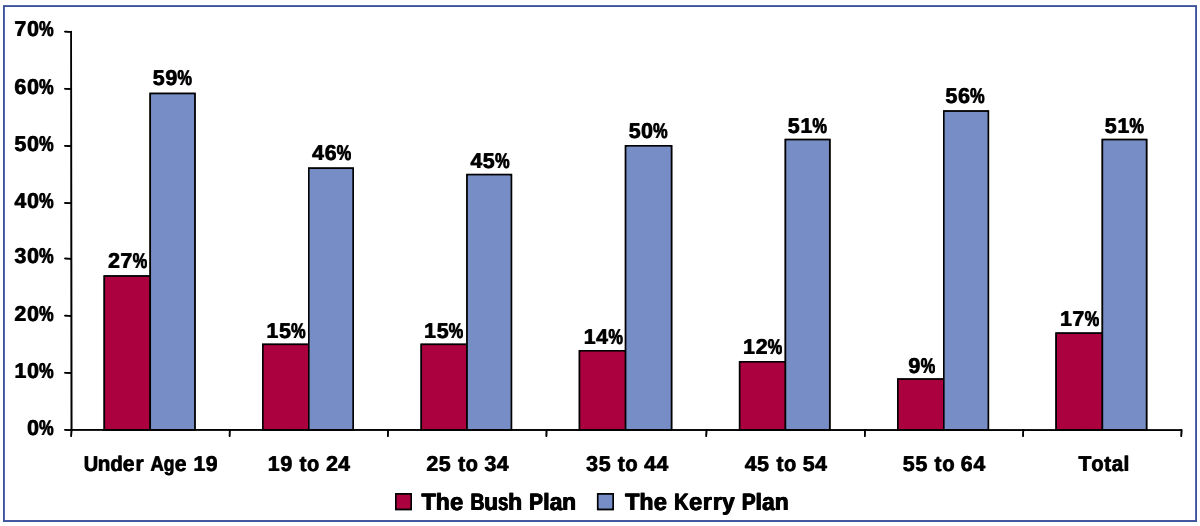
Figure 1:
Changes in Primary Source of Health Insurance for Americans: 2006[a/]
(in millions)

	Current Law	The Bush Plan		The Kerry Plan	
		Change	Number	Change	Number
People by Primary Sources of Coverage					
Employer Coverage	160.2	(1.2)	159.0	2.1	162.3
Non-group Coverage	10.0	8.0	18.0	1.5	11.5
Medicaid/SCHIP[b/]	30.4	1.4	31.8	21.6	52.0
Medicare[b/]	35.1	--	35.1	--	35.1
TRICARE/Military[c/]	4.0	--	4.0	--	4.0
Uninsured	49.5	(8.2)	41.3	(25.2)	24.3
Total Population	289.1	N/A	289.1	N/A	289.1

Columns may not sum to totals due to rounding.
a/ Assuming both plans are implemented in 2006.
b/ Medicaid recipients also covered under Medicare are counted with Medicare.
c/ Coverage expansion for National Guard not included in the analysis.
Source: The Lewin Group estimates.

The Bush plan would cover about 17% of the uninsured, while the Kerry plan would cover about 51% (***Figure 2***). Both proposals tend to cover a greater share of children than adults. The Bush plan would cover about 27% of all uninsured children, compared with 59% of all uninsured children becoming covered under the Kerry plan.

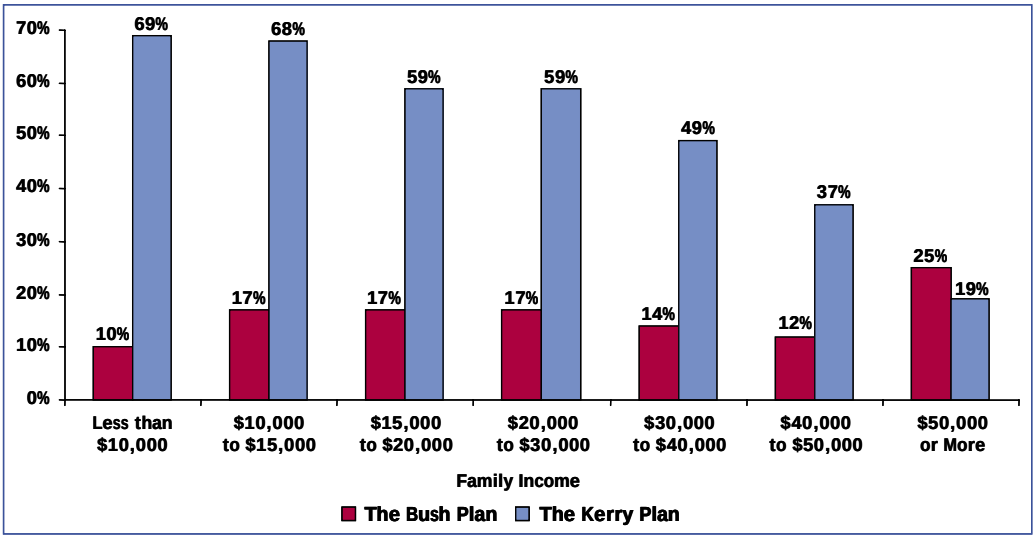
Figure 2:
Percent of Uninsured Covered Under the Candidates' Plans by Age: 2006[a/]



a/ Assuming both plans are implemented in 2006.
Source: The Lewin Group estimates.

While the Bush plan covers up to 17% of uninsured people with incomes below $50,000, it covers about 25% of uninsured people with incomes of $50,000 or more (***Figure 3***). This is because the HSA tax deduction tends to result in substantial tax savings to people in upper income groups. About 20% of the uninsured have a marginal tax rate of 25% or more.

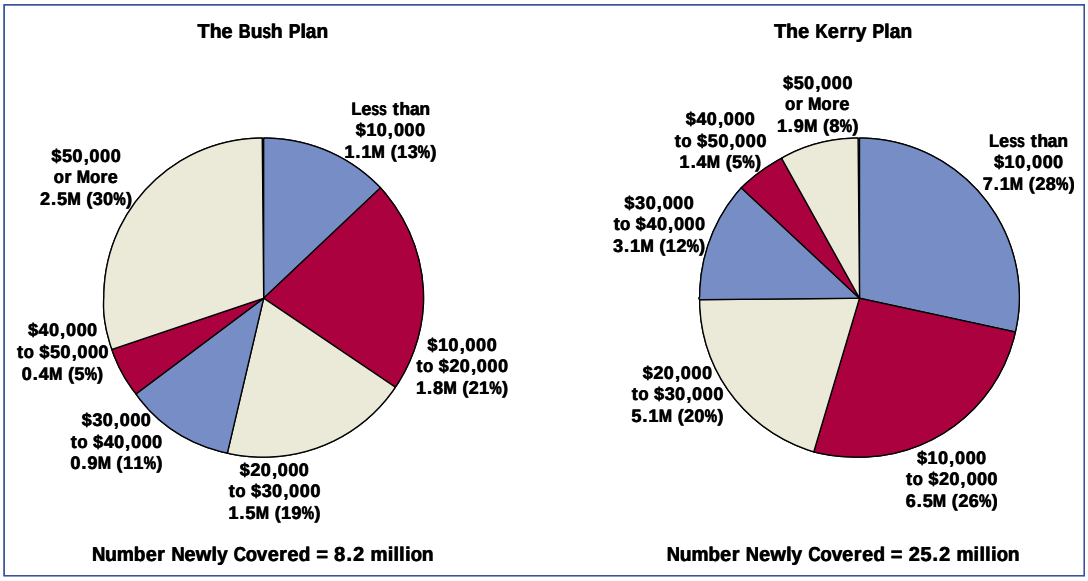
Figure 3:
Percent of Uninsured Covered Under the Candidates' Plans by Family Income: 2006[a/]



a/ Assuming both plans are implemented in 2006.
Source: The Lewin Group estimates.

The distribution of newly insured people by income differs across the two plans. About 28% of newly insured people under the Kerry plan (7.1 million) would have incomes of $10,000 or less, while only about 13% of newly insured people under the Bush plan (1.1 million) would be in this income range (***Figure 4***). By contrast, about 30% of newly insured people under the Bush plan (2.5 million) would have incomes of $50,000 or more, compared with only about 8% of newly insured people under the Kerry plan.

Figure 4:
Distribution of Uninsured Covered Under the Candidates' Plans by Family Income: 2006[a/]

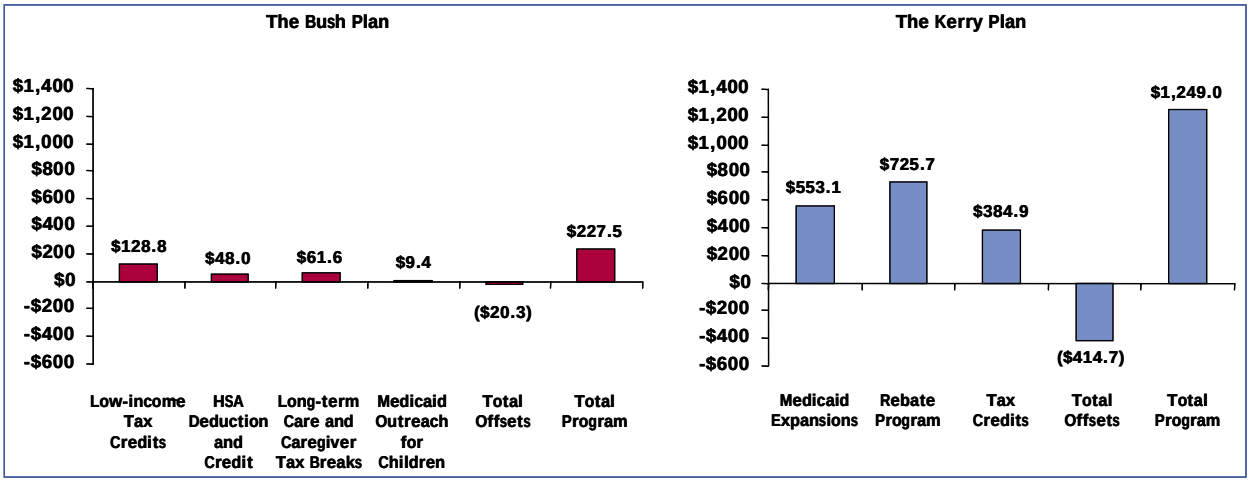


May not sum to totals due to rounding.
a/ Assuming both plans are implemented in 2006.
Source: The Lewin Group estimates.

II. Federal Program Costs

The Bush plan would increase federal spending net of offsets by about $227.5 billion over the 2006 through 2015 period (***Figure 5***). This includes $128.8 billion in tax credits to low-income people and about $42.8 billion in HSA tax deductions. The small employer tax credit for HSAs would cost about $5.2 billion over this period (total HSA deduction and credit cost is $48.0 billion [$42.8 + $5.2]), and federal Medicaid spending would increase under the outreach program by about $9.4 billion. In addition, the Bush plan includes about $61.6 billion in tax deductions for long-term care insurance and the home caregiver exemption. There would be offsets of about $20.3 billion for a net cost of $227.5 billion.

Figure 5:
Total Federal Health Spending for the Candidates' Plans Compared: 2006 – 2015
(in billions)



May not sum to totals due to rounding.
Numbers in parentheses reflect savings.
Source: The Lewin Group estimates.

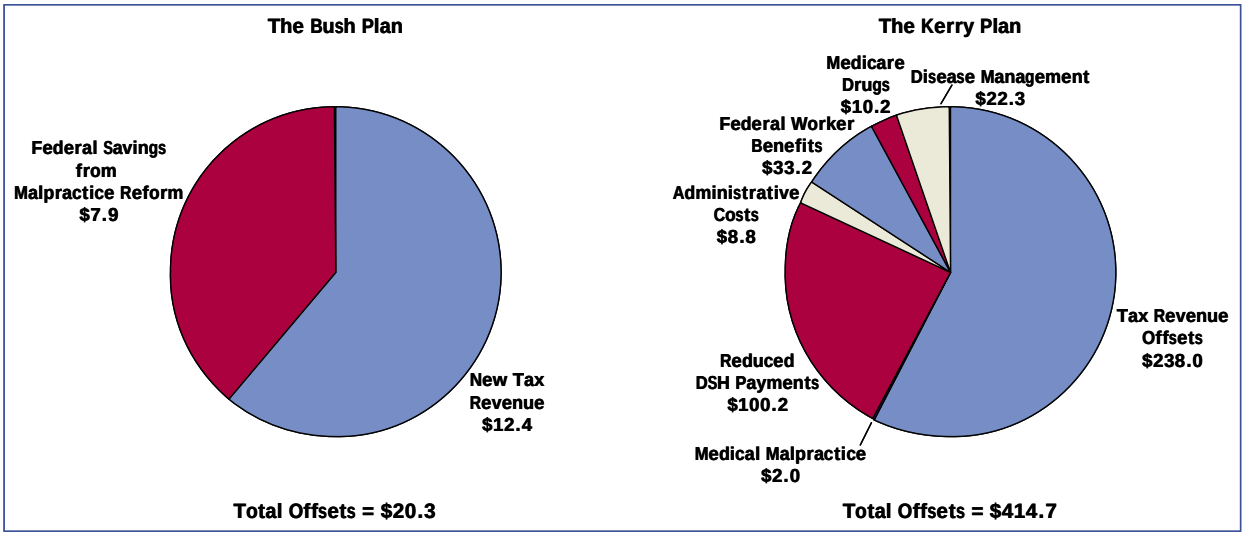
The Kerry plan would increase federal spending by about $1,249.0 billion net of offsets over the 2006 through 2015 period. The Medicaid expansion proposal would increase federal spending by about $553.1 billion over that period. This includes the cost of the federal government paying the full cost of Medicaid for children and the federal share of the cost of the various coverage expansions. The rebate program for private insurance (i.e., rebate for 75% of costs over $30,000 per beneficiary in 2006) would cost about $725.7 billion, and the tax credits for low- and moderate-income people would cost $384.9 billion.

Offsets under the program would be about $414.7 billion over this period. Most of this would be increased tax revenues, due to reductions in employer health benefits costs resulting from the small employer tax credit and the rebate program, as well as reduced disproportionate share hospital (DSH) payments under the Medicare and Medicaid programs. We assume that these savings to employers ultimately would be passed on to workers in the form of higher wage growth. This automatically would result in increased federal tax revenues that would help offset the costs of the coverage expansions under his plan.

Figure 6 presents the offsets to the new spending under the candidates' plans by source for 2006 through 2015. Offsets under the Bush plan include about $7.9 billion in savings to federal health benefits programs, resulting from the malpractice reform provisions of the proposal. There also would be an increase in income and payroll tax revenues of about $12.4 billion, reflecting reductions in employer spending under the plan. As discussed below, this occurs due to a small number of employers discontinuing their health plans. This would result in higher worker incomes subject to taxation. As discussed below, these employer savings reflect the discontinuation of coverage by some employers and reduced cost-shifting due to the reduction in the number of uninsured.

Federal offsets under the Kerry plan arise from several sources. The rebate and employer tax credit proposals would reduce employer spending, resulting in higher wage growth over the 2006 through 2015 period and an increase in federal tax revenues of about $238 billion. There also would be savings of about $33.2 billion for federal worker health benefits by participating in the premium rebate program. Additional savings would arise from disease management ($22.3 billion) and administrative savings ($8.8 billion), as well as medical malpractice reform. In addition, the Kerry plan would reduce disproportionate share hospital payments by half, resulting in savings of $100.2 billion over this period.[2]

Figure 6:
Sources of Federal Offsets Under the Candidates' Proposals: 2006 – 2015
(in billions)



May not sum to totals due to rounding.
Source: The Lewin Group estimates.

A detailed accounting of federal expenditures under the candidates' health plans is presented in ***Figures 7*** and *8*.

[2] Written communication from the Senator Kerry Campaign.

Figure 7:
Net Impact of the Bush Plan on Federal Health Spending: 2006 – 2015[a/]
(in billions)

	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	Total
Tax Coverage Expansion Proposals											
Low-income Tax Credits	$7.7	$9.4	$10.8	$11.7	$12.5	$13.4	$14.3	$15.3	$16.3	$17.4	$128.8
HSA Deductions	$2.1	$3.0	$3.7	$3.9	$4.2	$4.5	$4.8	$5.2	$5.5	$5.9	$42.8
Long-term Care Insurance Deduction	$1.8	$2.0	$2.3	$2.5	$2.7	$3.0	$3.2	$3.5	$3.7	$3.9	$28.6
Home Caregiver Exemption	$0.5	$0.9	$1.8	$2.8	$3.1	$3.6	$4.3	$4.7	$5.3	$5.9	$33.0
Small Employer Tax Credit	$0.3	$0.4	$0.4	$0.5	$0.5	$0.5	$0.6	$0.6	$0.7	$0.7	$5.2
Medicaid Outreach	$0.6	$0.8	$1.1	$0.8	$0.8	$0.9	$1.0	$1.1	$1.1	$1.2	$9.4
Total Coverage Expansions	$13.0	$16.5	$20.1	$22.2	$23.8	25.9	$28.2	$30.5	$32.6	$35.0	$247.8
Offsets											
Malpractice Reform Savings	$0.2	$0.3	$0.5	$0.8	$0.9	$0.9	$1.0	$1.0	$1.1	$1.2	$7.9
Tax Revenues, Increase	$0.6	$0.9	$1.1	$1.1	$1.2	$1.3	$1.4	$1.5	$1.6	$1.7	$12.4
Total Offsets	$0.8	$1.2	$1.6	$1.9	$2.1	$2.2	$2.4	$2.5	$2.7	$2.9	$20.3
Net Program Cost											
New Program Spending Less Offsets	$12.2	$15.3	$18.5	$20.3	$21.7	$23.7	$25.8	$28.0	$29.9	$32.1	$227.5

Columns and rows may not sum to totals due to rounding.
a/ Other published estimates use the 2006 through 2014 period. The Lewin Group estimates the net impact of the Bush plan on federal health spending (new program spending less offsets) for 2006 through 2014 would be $195.4 billion.
Source: The Lewin Group estimates.

Figure 8:
Net Impact of the Kerry Plan on Federal Health Spending: 2006-2015[a/]
(in billions)

	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	Total
Medicaid Provisions											
Federal Government Pays Full Cost for Medicaid Children	$14.8	$15.9	$17.1	$18.4	$19.7	$21.1	$22.6	$24.2	$25.9	$27.6	$207.4
Expansion for Children	$2.1	$3.7	$5.0	$5.4	$5.8	$6.2	$6.6	$7.0	$7.5	$8.0	$57.3
Expansion for Parents	$5.0	$8.6	$11.5	$12.4	$13.3	$14.3	$15.2	$16.3	$17.4	$18.6	$132.4
Expansion for Single Adults	--	--	$7.5	$13.0	$17.4	$18.6	$19.9	$21.3	$22.7	$24.2	$144.6
Outreach Enrollment Bonus	$2.5	$3.9	$5.0	--	--	--	--	--	--	--	$11.4
Total Federal Medicaid	**$24.4**	**$32.1**	**$46.2**	**$49.1**	**$56.2**	**$60.2**	**$64.4**	**$68.8**	**$73.4**	**$78.4**	**$553.1**
Premium Rebate Program											
Employer Rebates	$49.9	$53.7	$57.8	$62.1	$66.6	$71.4	$76.3	$81.5	$87.0	$92.9	$699.2
Non-group Rebates	$1.2	$2.1	$2.5	$2.5	$2.5	$2.7	$2.9	$3.1	$3.3	$3.5	$26.5
Total Rebate	**$51.1**	**$55.8**	**$60.3**	**$64.6**	**$69.1**	**$74.1**	**$79.2**	**$84.6**	**$90.3**	**$96.4**	**$725.7**
Tax Credits for "Low- and Moderate-Income" People											
Small Employer Tax Credit	$8.9	$10.6	$12.2	$13.1	$14.0	$15.0	$16.1	$17.1	$18.3	$19.6	$144.9
Non-group Tax Credit	$10.8	$18.9	$22.2	$21.9	$22.2	$24.2	$26.3	$28.6	$31.1	$33.8	$240.0
Total Tax Credits	**$19.7**	**$29.5**	**$34.4**	**$35.0**	**$36.2**	**$39.2**	**$42.4**	**$45.7**	**$49.4**	**$53.4**	**$384.9**
Offsets											
Prescription Drug Provisions	$0.6	$0.7	$0.8	$0.8	$0.9	$1.0	$1.1	$1.3	$1.4	$1.5	$10.2
Disease Management	--	$0.5	$1.1	$1.8	$2.6	$2.8	$3.1	$3.2	$3.5	$3.7	$22.3
Administrative Savings through Advanced HIT	$0.2	$0.2	$0.6	$0.8	$1.2	$1.4	$1.4	$1.3	$1.2	$0.5	$8.8
Medical Malpractice	$0.0	$0.1	$0.2	$0.2	$0.2	$0.2	$0.2	$0.3	$0.3	$0.3	$2.0
FEHBP (primarily rebates)	$2.4	$2.6	$2.7	$2.9	$3.2	$3.4	$3.6	$3.9	$4.1	$4.4	$33.2
Tax Revenue Offsets (increase counted as offsets)	$17.0	$18.3	$19.7	$21.1	$22.7	$24.3	$26.0	$27.7	$29.6	$31.6	$238.0
Reduced DSH Payments	$6.7	$7.9	$9.2	$9.5	$10.0	$10.4	$10.9	$11.4	$11.8	$12.2	$100.2
Total Offsets	**$26.9**	**$30.3**	**$34.3**	**$37.1**	**$40.8**	**$43.5**	**$46.3**	**$49.1**	**$51.9**	**$54.3**	**$414.7**
Total Program Cost											
Total New Program Spending	$95.2	$117.4	$140.9	$148.7	$161.5	$173.5	$186.0	$199.1	$213.1	$228.2	$1663.7
New Program Spending Less Offsets	$68.3	$87.1	$106.6	$111.6	$121.5	$130.0	$139.7	$150.0	$161.2	$173.9	$1249.0

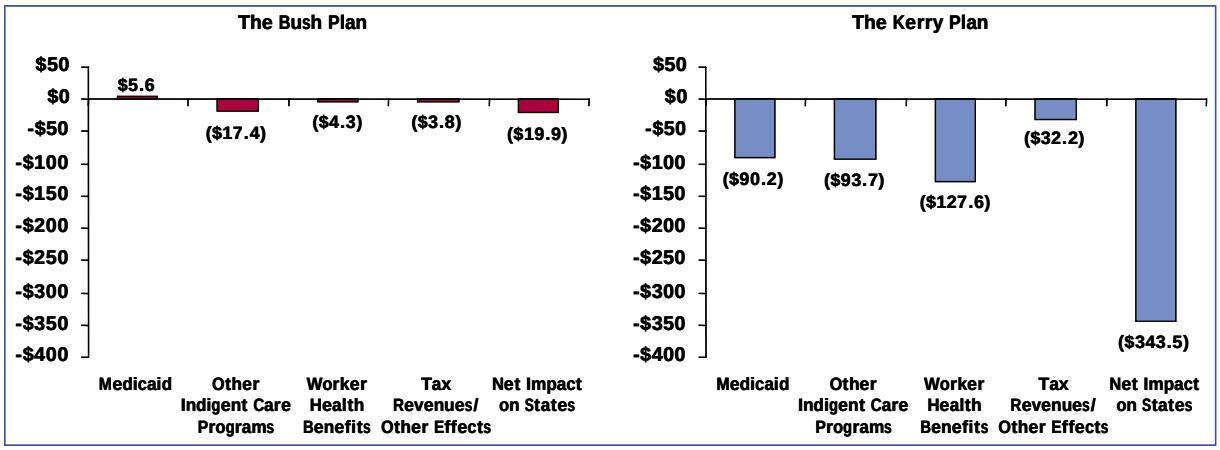
Columns and rows may not sum to totals due to rounding.
a/ Other published estimates use the 2006 through 2014 period. The Lewin Group estimates the net impact of the Kerry plan on federal health spending (new program spending less offsets) for 2006 through 2014 would be $1,075.1 billion.
Source: The Lewin Group estimates.

III. State Government Expenditures

Both of the candidates' plans would result in net savings to state and local governments. State and local government spending would be reduced by about $19.9 billion over the 2006 through 2015 period under the Bush plan, due primarily to reduced indigent care spending as uninsured people become covered with the help of federal tax credits and deductions. State and local government spending would be reduced by about $343.5 billion under the Kerry plan. Primarily, this is due to increased federal funding for the Medicaid eligible population and reduced state spending for indigent care programs.

Medicaid spending would increase by about $5.6 billion under the Bush plan (***Figure 9***). This is the state share of the cost of covering children who enroll as a result of the outreach program. This increase in spending would be more than offset by reduced spending under state and local government programs for the medically indigent of about $17.4 billion. These include savings to public hospitals, clinics, and other state and local programs serving the medically indigent.

Figure 9:
Summary Comparison of Candidates' Plans on State and Local Government Spending: 2006 - 2015 [a/] (in billions)



May not sum to totals due to rounding.
Numbers in parentheses reflect savings.
a/ Increased tax revenues counted as program offsets.
Source: The Lewin Group estimates.

State and local worker health benefits programs also would save about $4.3 billion under the Bush plan, due to reduced cost-shifting for the newly insured population. State health benefits programs also would save, due to malpractice reform under the Bush plan, and tax revenues would increase by about $1.6 billion, due to reductions in employer health care costs for privately insured people.

The Kerry plan has the effect of providing significant fiscal relief for states (***Figure 9***). States would save about $207.4 billion over this 10-year period as the federal government starts to pay the full cost of covering Medicaid eligible children. In most states, the reduction in state spending for children currently enrolled in Medicaid is more than enough to pay for the various expansions in Medicaid eligibility under the plan, including covering children to 300% of the FPL, parents to 200% of the FPL and single adults below poverty. A detailed summary of state and local government impacts is presented in ***Figures 10*** and ***11***.

Figure 10:
Impact of the Bush Plan on State and Local Governments: 2006 – 2015
(in billions)

	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	Total
State Share for Newly Enrolled Medicaid/ SCHIP Children	$0.2	$0.4	$0.5	$0.5	$0.6	$0.6	$0.6	$0.7	$0.7	$0.8	$5.6
Other Indigent Care Programs	($0.7)	($1.1)	($1.6)	($1.7)	($1.8)	($1.9)	($2.0)	($2.1)	($2.2)	($2.3)	($17.4)
State and Local Worker Health Benefits	($0.2)	($0.3)	($0.4)	($0.4)	($0.4)	($0.5)	($0.5)	($0.5)	($0.6)	($0.6)	($4.3)
Medical Malpractice Reform	($0.0)	($0.1)	($0.2)	($0.2)	($0.2)	($0.3)	($0.3)	($0.3)	($0.3)	($0.3)	($2.2)
Increase in State Income Tax Revenues											
State Income Tax Revenues	$0.1	$0.1	$0.1	$0.1	$0.1	$0.2	$0.2	$0.2	$0.2	$0.3	$1.6
Net Change in State Spending											
Net Change in State Spending	($0.8)	($1.2)	($1.8)	($1.9)	($1.9)	($2.3)	($2.4)	($2.4)	($2.6)	($2.7)	($19.9)

Columns and rows may not sum to totals due to rounding.
Numbers in parentheses reflect savings.
Source: The Lewin Group estimates.

Figure 11:
Impact of the Kerry Plan on State and Local Governments: 2006 - 2015
(in billions)

	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	Total
Medicaid Expansions											
Federal Government Pays Full Cost for Medicaid Children	($14.8)	($15.9)	($17.1)	($18.4)	($19.7)	($21.1)	($22.6)	($24.2)	($25.9)	($27.6)	($207.4)
Expansion for Children	$0.5	$0.8	$1.1	$1.2	$1.3	$1.4	$1.4	$1.5	$1.7	$1.8	$12.6
Expansion for Parents	$2.2	$3.8	$5.1	$5.4	$5.8	$6.3	$6.7	$7.1	$7.6	$8.1	$58.2
Expansion for Single Adults	--	--	$3.0	$5.2	$7.0	$7.4	$8.0	$8.5	$9.1	$9.7	$57.9
Enrollment Incentive Payments	($2.5)	($3.9)	($5.0)	--	--	--	--	--	--	--	($11.4)
Total Medicaid	**($14.6)**	**($15.2)**	**($12.9)**	**($6.6)**	**($5.6)**	**($6.0)**	**($6.5)**	**($7.1)**	**($7.5)**	**($8.0)**	**($90.2)**
Spending for Other State and Local Health Programs											
Other Indigent Care (public hospitals, etc.)	($3.2)	($5.9)	($8.1)	($9.1)	($9.9)	($10.4)	($11.0)	($11.5)	($12.0)	($12.6)	($93.7)
State and Local Worker and Retiree Health Benefits	($9.1)	($9.8)	($10.5)	($11.3)	($12.2)	($13.0)	($14.0)	($14.9)	($15.9)	($16.9)	($127.6)
Total Other Programs	**($12.3)**	**($15.7)**	**($18.6)**	**($20.4)**	**($22.1)**	**($23.4)**	**($25.0)**	**($26.4)**	**($27.9)**	**($29.5)**	**($221.3)**
Other Effects											
Require Insurers to Use Advanced HIT	($0.0)	($0.1)	($0.1)	($0.3)	($0.3)	($0.4)	($0.3)	($0.3)	($0.2)	($0.2)	($2.2)
Medical Malpractice Reform	($0.0)	($0.0)	($0.0)	($0.1)	($0.1)	($0.1)	($0.1)	($0.1)	($0.1)	($0.2)	($0.8)
Total Other Effects	**($0.0)**	**($0.1)**	**($0.1)**	**($0.4)**	**($0.4)**	**($0.5)**	**($0.4)**	**($0.4)**	**($0.3)**	**($0.4)**	**($3.0)**
Increases in State Income Tax Revenues											
State Income Tax Revenue Increases	$2.1	$2.2	$2.4	$2.6	$2.8	$3.0	$3.2	$3.4	$3.6	$3.9	$29.2
Net Costs (Savings) for States											
Net Cost (savings)	**($29.0)**	**($33.2)**	**($34.0)**	**($30.0)**	**($30.9)**	**($32.9)**	**($35.1)**	**($37.3)**	**($39.3)**	**($41.8)**	**($343.5)**

Columns and rows may not sum to totals due to rounding.
Numbers in parentheses reflect savings.
Source: The Lewin Group estimates.

Under the Kerry plan, spending for state and local public indigent care programs would be reduced by about $93.7 billion, due to the reduction in the number of uninsured under the plan. State and local worker benefits programs also would save $127.6 billion by participating in the federal premium rebate program created under the Kerry plan. In addition, state income tax revenues would increase by $29.2 billion, due to increases in wage growth attributable to the reduction in health benefits costs under the plan.

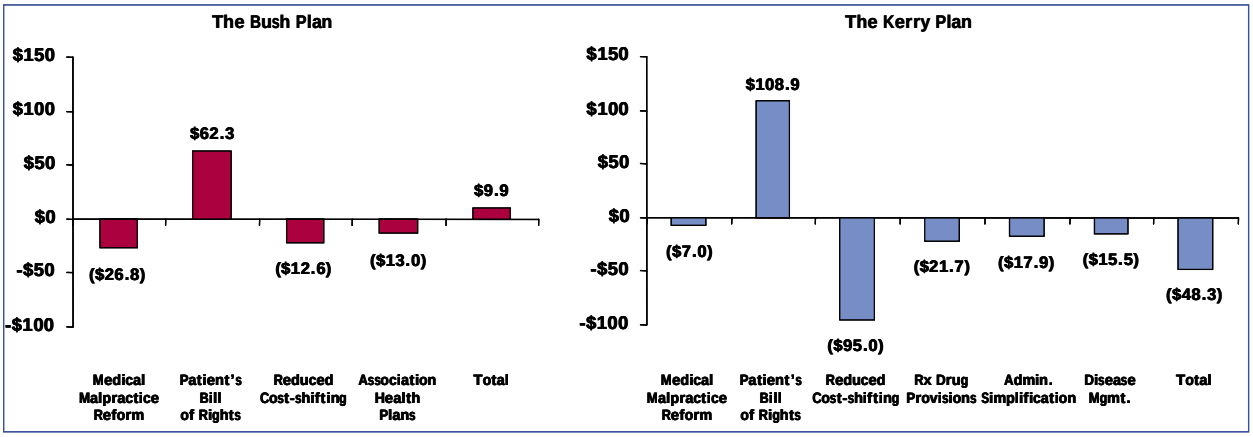
IV. Impact on Private Insurance Market

Both of the candidates' plans include provisions that would have an impact on private insurance costs. Both propose medical malpractice reform and support a patient's bill of rights, but the details of their plans are quite different. Both candidates' plans also would result in reduced cost-shifting for uncompensated care because they both reduce the number of uninsured. However, there are several provisions that are unique to each candidate.

A. Medical Malpractice Reform

Both candidates propose medical malpractice reforms. The Bush plan emphasizes limits on malpractice awards and other provisions designed to moderate the size of awards. The Kerry provisions are a series of procedural steps that are designed to guard against unwarranted claims. Based upon available research on the impact of similar reforms implemented at the state level, we estimate that the Bush plan would reduce private health insurance premiums by about $26.8 billion over the 2006 through 2015 period. The Kerry plan would reduce private health insurance premiums by about $7.0 billion (***Figure 12***).

Figure 12:
Changes in Private Insurance Market Affecting Premiums, Prior to Considering Premium Rebate, Under the Candidates' Plans: 2006 – 2015 (in billions)



May not sum to totals due to rounding.
Numbers in parentheses reflect savings.
Source: The Lewin Group estimates.

B. Patient's Bill of Rights

Both candidates propose a patient's bill of rights that includes limitations on health plan practices to assure access to emergency and specialist care. The Bush plan would increase private insurance premiums by about $62.3 billion over the 2006 through 2015 period. The Kerry plan includes some of these same provisions, but would also permit people to sue health plans for decisions that have a negative impact on a patient's health. These provisions would increase costs for people in affected plans. The Kerry patient's bill of rights would increase costs by about $108.9 billion.

C. Reduced Cost-shifting

There would be savings under both plans due to reduced cost-shifting as a result of the reduction in uncompensated care for uninsured people. We estimate that, when fully implemented, uncompensated care costs for providers would decline by about $2.5 billion under the Bush plan and $18.8 billion under the Kerry plan in 2006. Historical data suggests that about $0.40 out of every $1.00 reduction in uncompensated care is passed back to private payers in the form of reduced growth in charges. Based upon these data, we estimate a reduction in the cost-shift of about $12.6 billion under the Bush plan and $95 billion under the Kerry plan over the 2006 through 2015 period.

D. Insurance Purchasing Pools

The Bush plan also proposes the creation of AHPs that would permit employers to obtain coverage that is exempt from state mandated benefits laws. This would reduce insurance premiums by about 5.0%, resulting in savings for participating firms of about $13.0 billion over the 2006 through 2015 budget window, along with a small net increase in coverage. We assume no savings in administration or benefits costs under these plans, however. This is based upon a CBO study and research articles indicating that existing purchasing pools have had little or no impact on the cost of insurance administration or benefits.

The Kerry plan proposes to create the CHP modeled on the FEHBP, which is the health plan that covers members of Congress. As in our analysis of the Bush AHP, we assume no savings in costs of administration or benefits under the program, reflecting the inherently high cost of administering coverage for small groups and individuals, even within purchasing pools. We also believe that few, if any, plans doing business in FEHBP are offering benefits that do not include most state mandated benefits. Consequently, we assume no savings overall under the CHP proposal.[3]

[3] Structuring this plan in a way that does not result in adverse selection (i.e., the accumulation of a disproportionately high share of high-cost cases) is discussed in ***Appendix D***.

E. Other Provisions of the Kerry Plan

The Kerry plan requires insurers doing business with the federal government to adopt disease management programs and advanced billing systems. This will affect all insurers providing coverage or administrative services to FEHBP health plans, administrators of Medicaid and Medicare programs, Medicare HMOs and Medicare Advantage health plans. The Kerry plan also includes incentives for providers to use the automated billing systems that insurers make available.

The available evidence indicates that much of the savings from disease management and advance billing systems already is occurring. One survey of health plans showed that 97% of all health plans have a disease management program for at least one health condition, and over half have disease management programs for four or more health conditions. Also, virtually all health plans have automated billing systems, and up to 80% of plans have automated remittance (i.e., provider payment and explanation of benefits) systems. Provider use of these systems also is growing at a rapid rate. Thus, most of these savings will occur over the next 10 years, regardless of whether either candidates' plans are implemented.

However, we assume that the Kerry plan accelerates the adoption of disease management and advanced health information technology resulting in savings. Savings over the 2006 through 2015 period would be about $15.5 billion for disease management and about $17.9 billion for administrative simplification. The data and assumptions used to estimate these effects are presented in ***Appendix D*** of this report.

In addition, the Kerry plan proposes several provisions designed to reduce prescription drug costs. These include tightening of laws permitting drug companies to effectively extend patent life, which delays entry of lower cost generic drugs, and permitting the reimportation of prescription drugs from other countries. Based upon analyses developed by the CBO, these provisions would reduce overall drug spending by about 1.0%, resulting in savings of $21.7 billion over the 2006 through 2015 period.

F. Combined Effects on the Private Insurance Markets

The combined effects of the Bush plan on private health insurance premiums would be an increase of about $9.9 billion over the 2006 through 2015 period. By contrast, the Kerry plan would reduce private insurance costs by about $48.3 billion over the same period. It is important to understand, however, that these cost effects are very small relative to the overall cost of private insurance over this 10-year period. For example, the effects of the Bush plan are equal to only about one-tenth of 1% of private insurance premiums over that period. The combined effects of the Kerry plan before considering his employer rebate proposal would reduce premiums by only about six-tenths of 1%.

The Kerry plan's employer rebate program is designed to reduce the cost of private insurance for participating firms by about 10% by offering qualifying employers a rebate for beneficiaries with catastrophic health care costs (in excess of $30,000 per individual in 2006). When the effects of this rebate are included, the total effect of the Kerry plan on private insurance premiums is a reduction in spending of about $773.9 billion over the 2006 through 2015 period. Detailed estimates of the effects of these provisions on private insurance costs are presented in ***Figures 13*** and ***14***.

Figure 13:
Impact of the Bush Plan on Private Insurance Plan Premiums Before Tax Credits: 2006 – 2015
(in billions)

	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	Total
Medical Malpractice Reform	($0.5)	($1.2)	($1.8)	($2.7)	($2.8)	($3.1)	($3.3)	($3.6)	($3.8)	($4.0)	($26.8)
Patient's Bill of Rights	$2.4	$4.1	$5.5	$5.9	$6.3	$6.7	$7.1	$7.6	$8.1	$8.6	$62.3
Savings from Reduced Cost-shift for Free Care[a/]	($0.5)	($0.8)	($1.1)	($1.2)	($1.3)	($1.4)	($1.4)	($1.5)	($1.6)	($1.8)	($12.6)
Association Health Plans	($0.9)	($1.0)	($1.1)	($1.2)	($1.3)	($1.3)	($1.4)	($1.5)	($1.6)	($1.7)	($13.0)
Net Change	**$0.5**	**$1.1**	**$1.5**	**$0.8**	**$0.9**	**$0.9**	**$1.0**	**$1.0**	**$1.1**	**$1.1**	**$9.9**

Columns and rows may not sum to totals due to rounding.
Numbers in parentheses reflect savings.
a/ About 40% of the reduction in uncompensated care is assumed to be passed back to private insurers in the form of reduced increase in charges over time.
Source: The Lewin Group estimates.

Figure 14:
Impact of the Kerry Plan on Private Insurance Plan Premiums Before Tax Credits: 2006 – 2015
(in billions)

	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	Total
Medical Malpractice Reform	($0.2)	($0.3)	($0.5)	($0.7)	($0.7)	($0.8)	($0.9)	($0.9)	($1.0)	($1.0)	($7.0)
Patient's Bill of Rights	$4.2	$7.2	$9.6	$10.3	$11.0	$11.7	$12.4	$13.3	$14.2	$15.0	$108.9
Administrative Costs	($0.4)	($0.6)	($1.2)	($1.7)	($2.6)	($3.1)	($2.6)	($2.5)	($2.0)	($1.2)	($17.9)
Disease Management	--	($0.9)	($2.6)	($2.5)	($2.3)	($2.2)	($1.9)	($1.5)	($1.1)	($0.5)	($15.5)
Cost-shifting for Free Care[a/]	($3.6)	($6.2)	($8.3)	($8.9)	($9.5)	($10.2)	($10.9)	($11.6)	($12.5)	($13.3)	($95.0)
Prescription Drug Provisions	($1.3)	($1.5)	($1.6)	($1.8)	($2.0)	($2.2)	($2.4)	($2.7)	($3.0)	($3.3)	($21.7)
Total Indirect Measures Affecting Premiums											
Subtotal	($1.3)	($2.3)	($4.6)	($5.3)	($6.1)	($6.8)	($6.3)	($5.9)	($5.4)	($4.3)	($48.2)
Effects of Premium Rebate											
Premium Rebate	($51.1)	($55.8)	($60.3)	($64.6)	($69.1)	($74.1)	($79.2)	($84.6)	($90.3)	($96.4)	($725.7)
Total Net Change											
Net Change in Spending	**($52.4)**	**($58.1)**	**($64.9)**	**($69.9)**	**($75.2)**	**($80.9)**	**($85.5)**	**($90.5)**	**($95.7)**	**($100.7)**	**($773.9)**

Columns and rows may not sum to totals due to rounding.
Numbers in parentheses reflect savings.
a/ About 40% of the reduction in uncompensated care is assumed to be passed back to private insurers in the form of reduced increase in charges over time.
Source: The Lewin Group estimates.

V. Employer Coverage and Costs

We estimate that there are about 160.2 million people with employer coverage potentially affected by the candidates' plans. This includes 81.4 million workers, 75.9 million dependents and 2.9 million early retirees. The total cost of employer health benefits for this population will be about $626.6 billion in 2006.[4] Worker contributions will pay for about 22.5% these premiums with the remainder paid by the employer.

Both plans potentially affect employer coverage and costs. The Bush plan includes a tax credit for small businesses who establish HSAs. The Kerry plan includes a substantial tax credit for small businesses with low- to moderate-income people that provide coverage. The Kerry plan also provides a premium rebate for 75% of costs in excess of $30,000 per beneficiary in 2006 (this amount would be indexed annually to the growth in health costs).

These programs are expected to induce some employers to start providing health insurance. However, as discussed below, the newly created tax credits for non-group insurance under both plans and the Medicaid expansions under the Kerry plan could reduce the relative tax advantages of offering employer coverage, resulting in some employers discontinuing the coverage they now offer.

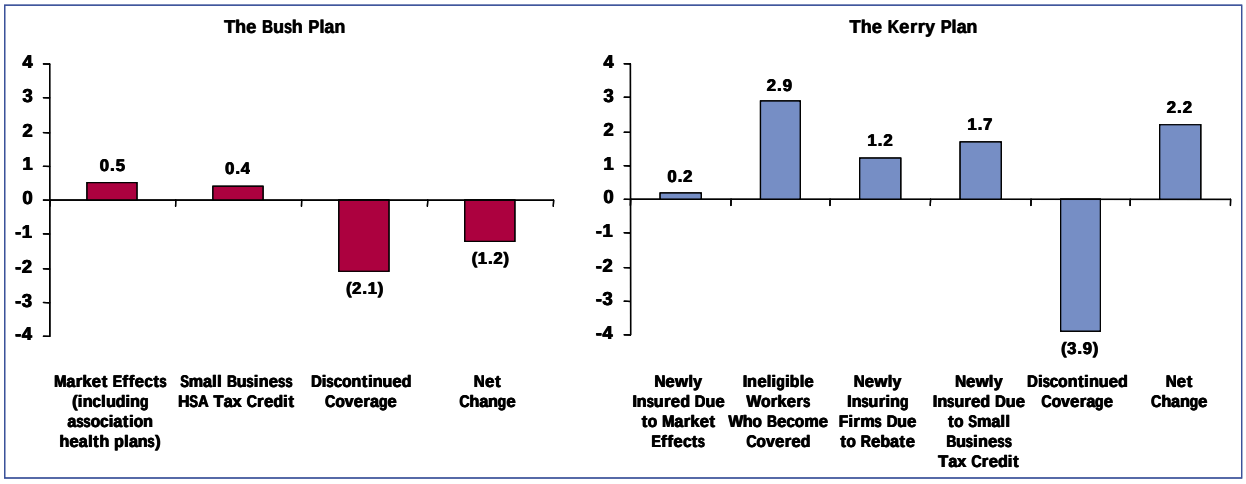
A. Changes in Employer Coverage

The Bush plan creates small business AHPs that are not subject to state mandated benefits laws, thus reducing the cost of insurance for small employers. We estimate that about 6.0 million people would enroll in these lower cost plans, of whom about 500,000 would be in firms that are induced to offer employer coverage due to the availability of lower cost coverage in AHPs (***Figure 15***). This estimate also includes the effects of other provisions in the Bush plan that affect premiums, such as medical malpractice reform and reduced cost-shifting for uncompensated care.[5]

[4] Retirees with Medicare coverage are largely unaffected by these proposals.

[5] The coverage effect for these changes in costs is less than 50,000 people.

Figure 15:
Changes in Employer Coverage Under the Candidates' Plans: 2006 [a/]
(in millions)



Numbers in parentheses reflect savings.
a/ Assuming both plans are implemented in 2006.
Source: The Lewin Group estimates.

We also estimate that about 400,000 people would be in firms that decide to offer coverage due to the availability of the Bush plan's tax credit to small businesses for HSA plans. As discussed above, the Bush plan provides a small business (firms under 100 workers) tax credit for up to $500 for a family and $200 for an individual. We also estimate that about 1.6 million people are in currently insuring firms that would be induced to change their coverage to an HSA to take advantage of the credit. This is in addition to the 400,000 people in firms that would decide to offer HSA coverage.

We estimate that about 2.1 million people are in firms that would discontinue coverage once their workers become eligible for a tax credit for the purchase of non-group coverage (our analysis of the decision to discontinue coverage is discussed below). After accounting for these changes in coverage, we estimate that the number of people with employer coverage would drop by about 1.2 million workers and dependents under the Bush plan.

The Kerry plan includes several provisions that would affect the employer's decision to provide coverage. For example, as a condition of participating in the premium rebate program, insuring employers must agree to provide coverage to all workers, including those who are now ineligible for their plan. In our analysis, we assume that all employers enroll in the program as long as the cost of covering their ineligible workers is less than the cost savings they would see by participating in the rebate. This results in employers covering about 2.9 million ineligible workers and dependents (***Figure 15***).

In addition, the premium rebate program effectively reduces the cost of insurance by about 10% for participating employers, which is likely to induce some employers to offer insurance coverage. We estimate that about 1.2 million workers and dependents would obtain coverage in this way. Similarly, the various provisions of the Kerry plan that reduce insurance costs (e.g., medical malpractice reform, administrative simplification, etc.) would increase the number of people with employer coverage by about 200,000 people.

The Kerry plan also includes a tax credit for small businesses with low- to moderate-income workers. The tax credit is equal to up to 50% of qualifying employers' premium contributions for worker health benefits. This effectively reduces the cost of insurance to the employer, resulting in an increase in the number of people with employer-sponsored coverage of about 1.7 million people.

Despite these inducements for employers to offer coverage, we estimate that there are about 3.9 million workers and dependents in firms that would decide to discontinue coverage. These are firms where enough workers would become eligible for Medicaid or the tax credit that they would decide to discontinue coverage.

B. Discontinuations of Coverage

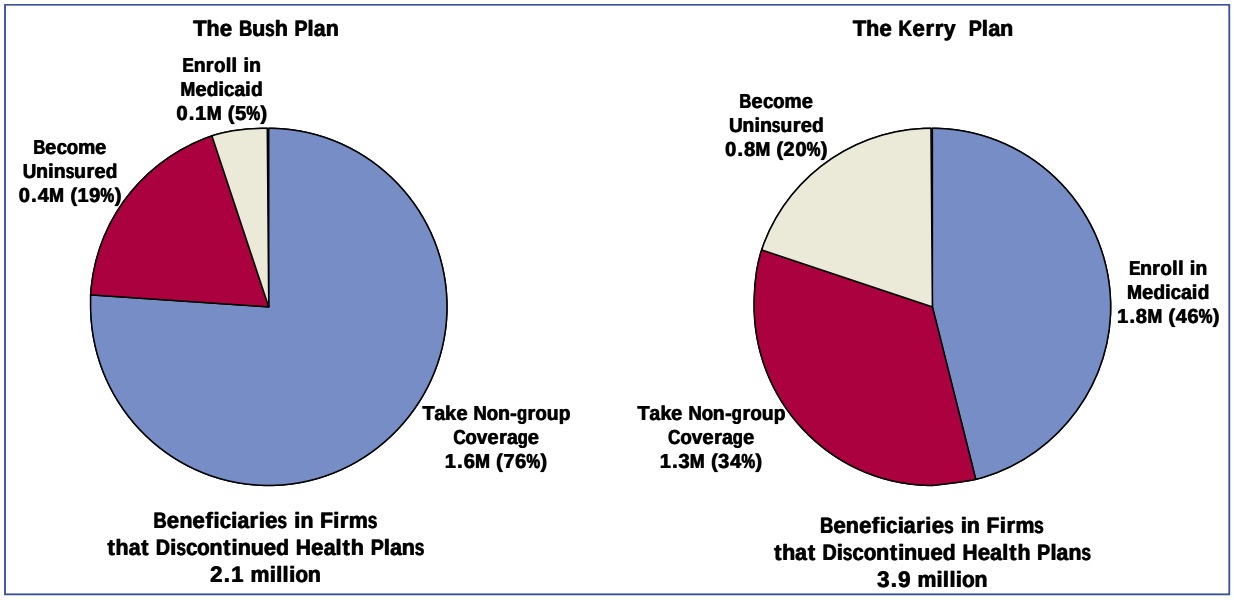
Both candidates create tax credits for non-group health insurance for those who do not have employer-sponsored coverage. These policies change the relative tax advantages of employer-sponsored insurance. Under the current tax code, employer contributions for health benefits are exempt from taxation for purposes of the income tax and Social Security payroll taxes, while there is little tax benefit provided to people who must obtain coverage on their own in the non-group market (non-group premiums are deductible only to the extent that they exceed 7.5% of filer income).

Providing subsidies for non-group coverage reduces the tax incentives for employers to provide coverage. The Kerry plan also extends eligibility under Medicaid to parents up to 200% of the FPL and single adults through 100% of the FPL, which would become the lowest cost alternative for workers at these income levels. The availability of subsidized coverage for working people reduces and potentially eliminates the relative benefits of obtaining coverage through an employer, which could cause some employers to discontinue their plans.

In our analysis, we have assumed that some employers would discontinue their health plans, in cases where their employees are able to obtain coverage at a lower cost through the tax credit for non-group insurance or under the expanded Medicaid program. We assume that employers "cash out" their health plans by discontinuing coverage and giving the savings to workers as wage increases, in cases where their workers can on average obtain subsidized coverage at a lower cost. This happens infrequently, because there are few employers who now provide insurance to a predominantly low-income workforce. However, because employer coverage is likely to be preferred to Medicaid or non-group coverage, we assume that only about half of employers in this situation actually terminate their plans.

Our models show that most of those who are in discontinued plans would obtain coverage once the employer plan is terminated. As shown in ***Figure 16***, we estimate that of the 2.1 million people in firms that discontinue coverage under the Bush plan, about 81% would obtain non-group coverage, usually with a tax credit that they would be eligible to receive. The remaining 19% (400,000 people) would become uninsured. Under the Kerry plan, all but 20% of the 3.9 million people in firms that discontinue coverage would obtain coverage under either the expanded Medicaid program or the non-group coverage with the help of the tax credit, and 20% would become uninsured.

Figure 16:
Workers and Dependents in Firms that Discontinue Employer Health Insurance Under the Candidates' Plans



Source: The Lewin Group estimates.

C. Changes in Employer Health Spending

Employer health spending would decline by about $4.7 billion under the Bush plan, which is a reduction of less than 1% (***Figure 17***). The increased coverage through AHPs would result in another $1.9 billion in premium payments for newly insured people. This would be offset partially by small business tax credit receipts of $400 million. There would be a reduction in premiums of $6.6 billion for people whose coverage is discontinued. Also, we show a small net increase in spending due to the various market reform provisions ($400 million).

Figure 17:
Changes in Employer Health Spending Under the Candidates' Plans: 2006[a/]
(in billions)

	The Bush Plan	The Kerry Plan
Current Employer Health Spending	$626.6	$626.6
Premiums for Newly Insured Workers	$1.9	$24.5
Small Business Tax Credits	($0.4)	($10.5)
Premium Rebates	N/A	($49.9)
Premiums for Workers With Discontinued Coverage	($6.6)	($12.2)
Other Market Effects[b/]	$0.4	($4.0)
Net Change in Employer Spending	($4.7)	($52.1)

Numbers in parentheses reflect savings.
a/ Assumes programs are fully implemented in 2006.
b/ Market effects are due to various reforms in the proposal, including malpractice reform, patient's bill of rights, administrative simplification and other provisions.
Source: The Lewin Group estimates.

Employer health benefits costs under the Kerry plan would be reduced by about $52.1 billion, which is a reduction of about 8.3%. There would be an increase in employer spending of about $24.5 billion for people in firms that decide to offer coverage. This would be more than offset by small business tax credits ($10.5 billion) and premium rebates ($49.9 billion) totaling $60.4 billion. In addition, we estimate savings of about $4.0 billion due to various reforms in the proposal, including malpractice reform, administrative simplification and other provisions discussed above.

Figure 18 presents the average changes in per-member per-month (PMPM) premiums under the candidates' proposals by firm size and industry (assumes a standard population).

Figure 18:
Changes in Average Employer Premiums by Firm Size and Industry, Assuming Full Implementation: 2006[a/]

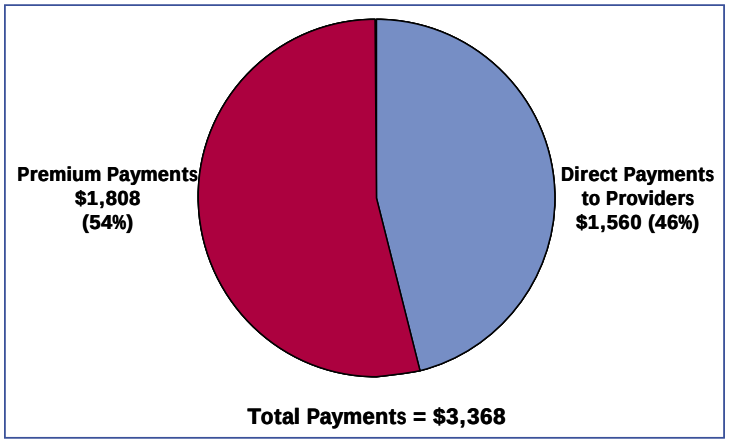
	Employer Premiums per Person per Month Under Current Law	Change in Premiums Under the Bush Plan	Change in Premiums Under the Kerry Plan
		Firm Size	
Under 10	$326	—[b/]	($60)
10 to 24	$305	—[b/]	($44)
25 to 99	$339	—[b/]	($25)
100 to 499	$316	—[b/]	($25)
500 to 999	$313	—[b/]	($22)
1,000 to 4,999	$309	—[b/]	($24)
5,000 or more	$307	—[b/]	($25)
Government	$325	—[b/]	($27)
		Industry	
Construction	$281	—[b/]	($30)
Manufacturing	$300	—[b/]	($24)
Transportation	$367	—[b/]	($30)
Wholesale	$299	—[b/]	($31)
Retail	$284	—[b/]	($24)
Services	$338	—[b/]	($37)
Finance	$295	—[b/]	($33)
Federal	$304	—[b/]	($24)
State and Local	$331	—[b/]	($27)
Other	$333	—[b/]	($46)
Average Overall	$317	—[b/]	($30)

Numbers in parentheses reflect savings.
a/ Reflects rebates and credits. Averages across employers participating and not participating in the rebate (assumes a standard population).
b/ Change of less than $1.0
Source: The Lewin Group estimates.

VI. Impact of Candidates' Plans on Consumers

We estimate that average annual out-of-pocket health spending will be about $3,368 per family in 2006 under current law (***Figure 19***). This includes direct payments for care of $1,560, which includes co-payments, deductibles and purchases of services not covered by a health plan. It also includes premium payments averaging about $1,808 per family. This includes the employee share of the premium for employer-sponsored insurance, premiums for non-group coverage and the Medicare Part-B premium for Medicare covered people.

Figure 19:
Average Family Health Spending Under Current Law: 2006



Source: The Lewin Group estimates.

Under current law, average annual family out-of-pocket spending for health services and premiums increases from an average of about $1,504 for families headed by someone under age 25 to an average of $4,618 for families headed by someone age 65 or older (***Figure 20***). Out-of-pocket spending also varies from about $1,653 for families with incomes below $10,000 to $5,045 for families with incomes of $150,000 or more.

Figure 20:
Detailed Changes in Average Annual Family Health Spending Under the Candidates' Plans by Family Characteristics: 2006[a/, b/]

	The Bush Plan					The Kerry Plan			
	Average Family Health Spending Under Current Law	Change in Average Family Premium Payments	Change in Average Family Out-of-Pocket Spending	Wage Effects[c/]	Net Impact	Change in Average Family Premium Payments	Change in Average Family Out-of-Pocket Spending	Wage Effects[c/]	Net Impact
Family Income									
Less than $10,000	$1,653	($54)	$20	$21	($55)	($256)	($348)	$64	($668)
$10,000 to $19,999	$2,536	$5	$105	$13	$97	($201)	($178)	$101	($480)
$20,000 to $29,999	$3,054	$46	$8	$43	$11	($169)	($87)	$153	($409)
$30,000 to $39,999	$3,143	$60	$48	$60	$48	($124)	($51)	$275	($450)
$40,000 to $49,999	$3,399	$75	$52	$76	$51	($47)	($9)	$374	($430)
$50,000 to $74,999	$3,843	$66	$68	$60	$74	($30)	$59	$410	($381)
$75,000 to $99,999	$4,097	$101	$66	$64	$103	($44)	$85	$462	($421)
$100,000 to $149,999	$4,377	$141	$67	$66	$142	$0	$109	$483	($374)
$150,000+	$5,045	$149	$107	$78	$178	($36)	$71	$475	($440)
Age of Head of Household									
Under 25	$1,504	($1)	$9	$73	($65)	($85)	($73)	$179	($337)
25 to 34	$2,304	$92	$47	$61	$78	($104)	($10)	$294	($408)
35 to 44	$3,063	$110	$56	$55	$111	($44)	($21)	$373	($438)
45 to 54	$3,746	$69	$100	$71	$98	($117)	($80)	$428	($625)
55 to 64	$4,155	$25	$106	$41	$90	($264)	($128)	$341	($733)
65+	$4,618	$11	$23	$13	$21	($67)	($6)	$90	($163)
Current Premium and Out-of-Pocket Spending									
Less than $1,000	$341	$142	$24	$7	$159	$113	$5	$8	$110
$1,000 to $2,500	$1,711	$98	$49	$45	$102	$26	($15)	$292	($281)
$2,500 to $5000	$3,636	$32	$97	$75	$54	($60)	$4	$440	($496)
$5,000 to $10,000	$6,913	($23)	$95	$87	($15)	($358)	($40)	$503	($901)
$10,000 and Over	$14,866	($178)	($18)	$71	($267)	($1,423)	($834)	$423	($2,680)
Insurance Status									
All Uninsured	$1,304	$406	($88)	($35)	$353	$268	($634)	($251)	($115)
Some Insured	$3,525	$32	$71	$57	$46	($136)	($3)	$336	($475)
Total	$3,368	$59	$60	$51	$68	($108)	($48)	$295	($451)

a/ Assuming both plans are implemented in 2006.
b/ Numbers in parentheses reflect savings.
c/Increased wages are counted as a net reduction in family health spending.
Source: The Lewin Group estimates.

A. Changes in Average Annual Family Health Spending Under Proposals

Both of the candidates' plans would affect out-of-pocket spending for health care. We also estimate that increases in employer health spending would be passed on to workers in the form of changes in the rate of growth in wages over time. This is based upon economic theory and research showing that changes in employer health spending historically have been passed back to workers in the form of changes in wage growth. Also, the Kerry plan requires employers to pass the benefits of the rebates back to workers as a condition of enrollment (it is unclear how this would be enforced).

The Bush plan would increase average family premium payments by an average of $59 per family. This is total family premium payments under the Bush plan less tax credits and the value of tax deductions received. This reflects the fact that nearly all of the newly insured people under the tax credit would be paying at least a small amount of the premium themselves. The increase also reflects a shift of people from employer coverage to non-group coverage in cases where employers discontinue their health plans.

Direct payments for services also would increase by about $60 per family under the Bush plan. The primary reason for this is that newly insured people, who we estimate will increase their use of health services by about one-third once insured, would pay some amount of cost-sharing under their plans (e.g., deductibles, co-payments, etc.). It is important to note, however, that much of the increases in premium payments and co-payments for health services by the newly insured reflect voluntary decisions to purchase coverage and use more services once covered.

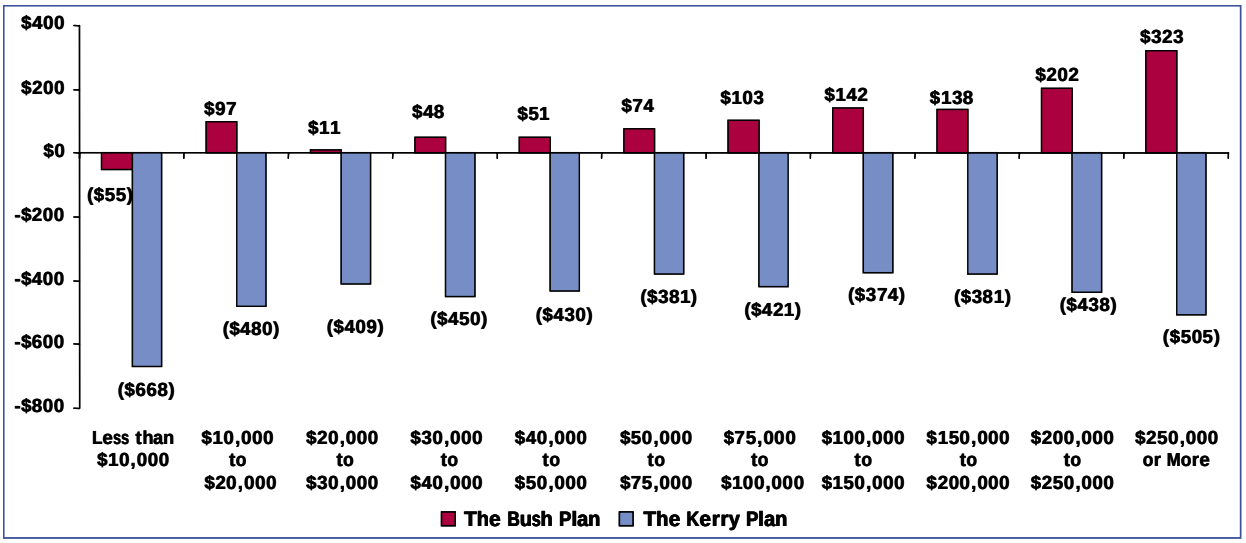
We assume that wages would increase by an average of about $51 per family, due to employer savings from the HSA tax credit and the cash-out of health benefits among plans that discontinue coverage. We count these wage increases as an offset to family health spending, which yields a net increase in average annual family health spending of about $68 per family under the Bush plan.

The Kerry plan would reduce average annual net family health spending by an average of about $451 per family. Average family premium payments would decline by about $108, and average direct payments for health services would decline by about $48. Wages would increase by about $295 per family under the Kerry plan, which is due primarily to the reductions in employer health benefits costs resulting from the small business tax credits and the premium rebate program. For illustrative purposes, we count this reduction as an offset to family health spending.

B. Impacts by Income and Age

Figure 21 shows the change in average family health spending, including wage effects, under these plans by family income. The Bush plan reduces spending for people with less than $10,000 in annual income by about $55 per family, with average spending increasing for families at higher income levels. By contrast, the Kerry plan, on average, reduces family health spending at all income levels.

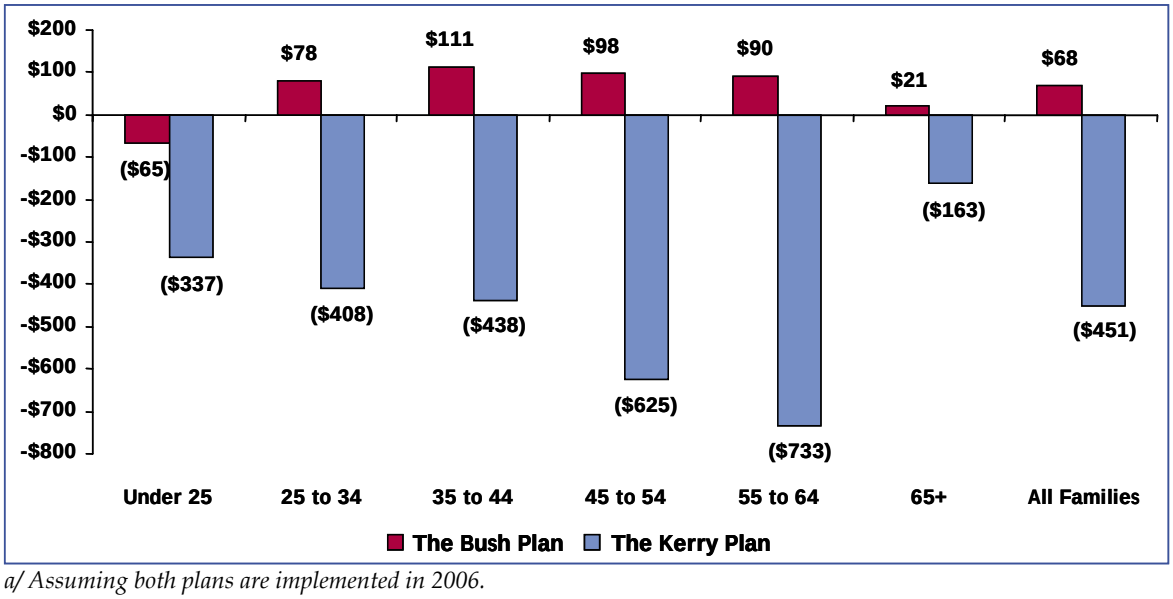
Figure 21:
Net Change in Family Health Spending by Family Income Under the Candidates' Plans with No Changes in Taxes: 2006[a/, b/]



May not sum to totals due to rounding.
a/ Assuming both plans are implemented in 2006.
b/ Numbers in parentheses reflect savings.
Source: The Lewin Group estimates.

Figure 22 shows the average change in family health spending by age of family head. The Bush Plan results in a relatively small increase in average family spending in all of the age groups shown except for people headed by someone under age 25. This is largely due to the expansion in Medicaid coverage for children, who tend to be in families with parents in this age group.

Figure 22:
Net Change in Family Health Spending by Age of Family Head Under the Candidates' Plans with No Changes in Taxes: 2006[a/, b/]



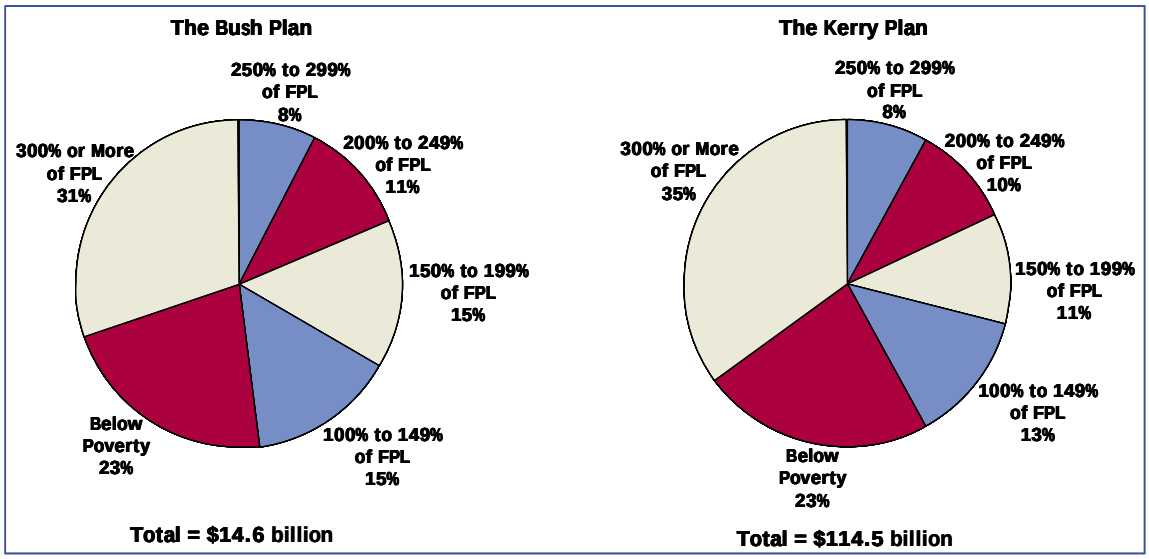
a/ Assuming both plans are implemented in 2006.
b/ Numbers in parentheses reflect savings.
Source: The Lewin Group estimates.

The Kerry plan shows a reduction in average family health spending in all age groups. Savings increase with age from an average of $337 for families with a head of household under the age of 25 to savings of $733 among families headed by someone age 55 to 64.

C. Distribution of Subsidies by Income Group

Figure 23 presents the distribution of program benefits and subsidies across families by income group for both plans. This includes the value of Medicaid, tax credits and deductions provided under the program, together with the value of employer tax credits and premium rebates.[6] Under both proposals, 23% of subsidies would go to people with incomes below the FPL. The percentage of subsidies going to families living above 300% of the FPL would be 31% under the Bush plan and 35% under the Kerry plan.

Figure 23:
Distribution of Benefits Under the Candidates' Plans by Family Income: 2006[a/]



May not sum to totals due to rounding.
a/ Includes the value of tax credits or Medicaid coverage received by individuals and the value of tax credits and rebates to their employer or health plan on their behalf. Amounts are offset by the increase in taxes paid, due to changes in employer benefit costs. Assumes full implementation in 2006.
Source: The Lewin Group estimates.

VII. Electronic Medical Records (EMRs)

Both of the candidates propose to take steps to expand the use of new health information technologies. The centerpiece of these systems is an electronic medical record (EMR) that includes patient medical histories, results of laboratory and radiology tests and detailed information on prescribed medications. A primary focus of this technology is to bring together

[6] Taxes paid on wage increases resulting from the effects of employer tax credits and rebates are subtracted to calculate a net value.

all of the medical information for each patient in an easily accessible system that enables physicians to make better treatment decisions and reduce costly medical errors.

There is evidence that elements of the EMR can be effective in reducing medical errors involving prescribing drugs, which often result in costly hospitalizations. These systems also can be integrated with computerized diagnostic tools and treatment guidelines to improve medical decision-making and perhaps extend patient longevity. While most experts feel that these systems would improve quality, there is little hard evidence that such systems would result in significant health system savings. The most likely area of savings would be reduced adverse drug reactions attributed to errors in prescribing medications. However prescribing errors are only one of the many sources of medical errors.

A substantial investment is required to establish such a system nationwide. Based upon IT industry cost data, we estimate that the cost of installing these systems in hospitals and physicians' offices throughout the country would be between $27.3 billion and $50.2 billion. Despite these costs, the industry is now moving to adopt these systems at a rapid rate. One survey of hospitals indicated that, while only 5% of hospitals had elements of an EMR in 2003, about 25% indicated that they will begin implementing such systems by 2006. This is a rapid rate of growth.

It is unclear whether the candidates' policies would accelerate this trend. The Bush plan proposes to increase federal funding for demonstrations of these systems by about $50.0 million. The Kerry plan proposes to provide "health care organizations and physicians with financial bonuses for investing in modern information technologies," but does not specify the amounts to be made available. In view of the size of the investment required to adopt this technology system wide, we have assumed that these programs would be too small to significantly accelerate the current trend towards adopting an EMR. Consequently, we score neither costs nor savings under either of these proposals.

VIII. Caveats

Although our analyses are based upon the best data and research of which we know, our estimates should be considered illustrative of potential impacts rather than point estimates of actual outcomes. Our estimates largely are based upon analyses of how changes in the cost of insurance affect decisions by employers and individuals to offer or take coverage. We assume that people would respond to a tax credit or deduction as though it were a reduction in insurance premiums. In fact, people may not equate these forms of subsidies with a simple price reduction and may not respond to these subsidies as expected.

We also make assumptions on how employers respond when tax subsidies and Medicaid coverage becomes available as a subsidized alternative to employer health benefits. Our estimates are based upon the assumption that employers would tend to drop their coverage if their workforce can obtain tax subsidized non-group or Medicaid coverage for a lower cost. However, we have no objective measures of how employers will respond. With what little is known, it is difficult to be sure of the likely impacts of changes in the relative tax advantages of employer insurance on the number of employers sponsoring coverage.

Our estimates of the impact of various changes in the health care system proposed by both candidates are speculative. These include medical malpractice reform, disease management, administrative systems and regulation of the managed care industry. In some cases, we are relying upon estimates of how these policies have affected costs when implemented in individual states or in various demonstration programs. We also have tried to supplement the available research with interviews with industry leaders and professionals who actually implement disease management programs and health care administrative systems. Despite this, there remains considerable uncertainty about the potential effects of these policies.

The appendices to this report present a detailed description of how we addressed each of the proposals presented by the candidates. We summarize the available literature in these areas and present the results of our interviews with industry experts. We then explain the assumptions we made to model the impacts of these policies and explain how estimates were developed from these assumptions. We invite interested parties to review these materials and comment on our approach.