HEALTH REFORM IN THE 2004 ELECTION
AN OVERVIEW OF THE PLANS

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Health Insurance Expansions, 2004: Examining the Options

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Health reform has resurfaced as a major policy priority and promises to be a central issue in the upcoming Presidential election. Virtually all of the candidates in the Democratic primary have issued detailed health reform plans. Similarly, President Bush has put his 2000 health reform proposal in his budgets for the past three years. This attention is not surprising, given recent events. The growing ranks of the uninsured, resurgence of health care cost growth, and persistent weak economy have propelled health care to the front of Americans' concerns. However, as history has taught, interest has far outrun progress on health reform. Perhaps the substance (or politics) of the new round of proposals will change this pattern.

This brief paper summarizes the Presidential candidates' plans and compares them on key dimensions. Specifically, it assesses, under each plan, where uninsured would get their coverage, how affordability of health coverage would be improved, who would be targeted for assistance, whether it provides universal coverage, and how health care costs are addressed. Numerous other questions can and should be asked of these plans; many of these are addressed in a companion piece, *Health Insurance Coverage Returns to the National Agenda: The Health Insurance Expansion Proposals of the 2004 Presidential Candidates*.[1] This paper's goal is to provide a snapshot of the fundamental similarities and differences in this new round of health reform plans.

THE PLANS

The following is a brief review of the health reform plans issued by Presidential candidates.[2] They are listed in an order that is convenient for comparison: those that rely predominantly on one type of health insurance first and then those that use hybrid systems for insuring Americans. Three plans are missing. Reverend Sharpton has stated his support for a constitutional amendment making health coverage a right; without details of how this would be accomplished, it cannot be assessed like the other plans. Ambassador Moseley Braun has indicated her support for a single payer system. Thus, her policy would closely resemble that of Representative Kucinich which is described below. The descriptions below are based on campaign documents and papers describing the plans as of October 30, 2003.

To put these plans in context, it is important to remember the underlying complexity of the U.S. health system. Americans get health insurance through multiple sources and about one in four nonelderly people experience a gap in health coverage at some point during the year.[3] Most get their insurance through employer-sponsored insurance (58%) (Figure 1).[4] Health benefits have historically been an important component of employee benefits, although the proportion of Americans getting health insurance through their own jobs and in large firms has been declining.[5] The second largest single source of coverage is Medicare.[6] Medicare, the only universal health insurance program in the nation, covers about 13 percent of Americans including virtually all seniors and certain nonelderly with disabilities who qualify for disability insurance. Medicaid and the State Children's Health Insurance Program (CHIP) are Federal-state programs that generally provide health and long-term care coverage to low-income and sick populations. While about 8 percent of Americans receive coverage through Medicaid/CHIP, a significant proportion of low-income Americans are not eligible for these programs due to Federal and/or state eligibility restrictions. Finally, a small fraction (5%) of Americans receives health insurance through the individual market. People move amongst these options frequently, and at any given time, 15 percent or 44 million Americans lack any type of health insurance.[7]

The complex web of health insurance coverage mirrors the way that government finances it. Employer contributions to workers' health insurance premiums are excluded from the workers' income, creating a Federal tax subsidy that ranges from 10 percent of the contribution for the lowest-income workers to 35 percent for the highest-income workers.[8] Despite its regressivity, the exclusion of employer health insurance premium contributions, valued at $80 to $108 billion in FY 2003, has been a major contributor to the central role that employers play in negotiating and paying for health benefits.[9] Including the state share of program costs, Medicaid / CHIP together are the second largest source of Federal subsidies for health coverage, funding over $284 billion in FY 2003.[10] Of this amount, the Federal government pays on average 57 percent ($162 billion) and states pay 43 percent ($122 billion), with each state's matching rate differing based on its relative per capita income. Like Medicaid, Medicare costs are high given the nature of its enrollees: $246 billion in FY 2003, net of beneficiary premiums. In addition, one study estimates that $35 billion is expended on uncompensated care annually for the uninsured.[11]

This picture of the current coverage and financing of health insurance is important to assessing the changes proposed by the various Presidential candidates. This is because, while some may seem overly complex, most options would, in fact, be less complicated than the current system.

President Bush. The President's FY 2004 budget contains approximately the same proposal that was in his 2000 campaign: a tax credit for people to purchase policies in the individual (non-group) market coverage (Figure 2).[12] The tax credit would be for 90 percent of the premium up to a cap of $1,000 for individuals, $3,000 for a family with two or more children. The credit would increase each year by the general inflation rate. The full credit would be available to those with income below $15,000 (single) and $25,000 (family) and would phase out, respectively, at $30,000 and $60,000. Only those without access to job-based or public insurance would qualify for the credit. No specific source of financing is indicated. Previous budgets and regulations have supported Medicaid savings, increasing access to generic drugs, promoting Medical Savings Account (MSA) types of policies, and supporting Congressional proposals for Association Health Plans. The emphasis of this proposal is on individual choice: the credit enables the eligible people to choose benefits packages that suit their needs.

Representative Kucinich. The Kucinich plan would expand Medicare to all Americans, eliminating the role of private insurers in the system (Figure 3). This single-payer approach would phase in coverage for children first and then older adults. It would not just be for the uninsured: all Americans would be moved into this new system. The exact benefits covered or premiums and cost sharing charged are not specified. The plan would be funded by replacing the current employer deduction for health insurance with a phased-in 7.7 percent payroll tax. Ambassador Moseley Braun also supports a single-payer system. The emphasis in this plan is on administrative simplicity: if the administrative overhead and insurer profits were taken out of the health care system, costs would go down and access would improve.

Representative Gephardt. The Gephardt plan would require all employers to offer health insurance, and would provide a 60 percent tax credit for their contributions to coverage (Figure 4). Employers not now offering coverage could apply the tax credit toward the full premium costs. To improve the affordability for lower-income workers, the plan includes a tax credit equal to 25 percent of their share of premium costs if their income is below 200 percent of the poverty level (about $37,000 in 2003 for a family of four). The plan would also allow states to cover the parents of children eligible for Medicaid / CHIP in those programs, and would create a Medicare buy-in for people ages 55 to 64. The plan would be financed by fully repealing the 2001 tax cut law. Representative Gephardt considers this legislation economic and well as health policy: it would redistribute tax revenue reductions more progressively, thus both reducing the uninsured and stimulating the economy.

Senator Kerry. The Kerry plan would create a new group health insurance option, modeled on the Federal Employees Health Benefits Plan, that would be accessible to all firms and individuals (Figure 5). Premiums for coverage would be subsidized through reinsurance (described below) and a tax credit that limits premiums as a percent of income. Small firms participating in the option would receive a tax credit of up to 50 percent of their contributions for low-wage workers. In addition, both the new group option and qualified employer-sponsored insurance would receive federal reinsurance. Specifically, the Federal government would pay 75 percent of qualified insurance claims that exceed $50,000 for an individual. The plan would also expand Medicaid / CHIP for children to 300 percent of poverty, parents to 200 percent of poverty, and childless adults to 100 percent of poverty. The Kerry plan places a strong emphasis on cost containment, and includes a number of policies to reduce health care costs for all Americans.

Governor Dean. The Dean health reform plan is also a "hybrid", building on existing pubic and private health insurance options as well as creating a new group option to help those who have fallen into the gaps (Figure 6). Its new group option would be for people in small firms or the individual insurance market and would be subsidized through a tax credit for premium costs that exceed 7.5 percent of participants' incomes. Reinsurance would be used to stabilize the new option. Workers in large firms paying high premiums could join the pool, and large firms would be given incentives and penalties to maintain affordable coverage. The plan would create new options for young adults and expands Medicaid / CHIP to 300 percent of poverty for children and 185 percent of poverty for adults. Its emphasis is on practicality and feasibility: identifying policies that could be enacted and implemented using systems in place today.

General Clark. The recently-released Clark health plan has three parts to its coverage initiative (Figure 7). Like Edwards, it would require coverage for all children (here defined as those age 22 and younger). Second, it would adopt a new group health insurance option like the Federal employees plan, as is done in the Kerry and Dean plans, with Federal assistance to stabilize premiums. Third, it would extend Medicaid / CHIP to 150 percent of poverty with sliding-scale tax credits to 275 percent of poverty for adults (500 percent of poverty for children). The cost of this expansion would be partially offset by $125 billion over 10 years in Federal health savings from policies such as Medicare competitive bidding for certain services. The plan would also create a commission whose focus is to improve the benefits covered by public and private health insurers. This underscores the theme of the Clark plan, which is "value". It aims to improve the "return on investment" in health coverage by focusing it on preventive services, disease management, cost effectiveness, and appropriate cost sharing.

Senator Lieberman. The Lieberman plan resembles that of Kerry and Dean in its use of existing and new group options, but is unique in its targeting of assistance to groups particularly likely to be uninsured (Figure 8). It targets children by, first, expanding Medicaid/CHIP and then creating "Medikids", a Medicare-like program open to all children and young adults. The plan would also expand Medicaid / CHIP to adults with income below 150 percent of poverty and provide refundable tax credits to adults above this income threshold for purchase of coverage in a new group option. The new group option would be accessible to certain groups of people like workers in small businesses, self-employed, seasonal workers, the near elderly, and the unemployed, among others. Tax credits for pool premiums that exceed 7.5 percent of income would be provided, and reinsurance would help stabilize the option. The plan also includes initiatives on research, prevention, quality and public health. The Lieberman plan aims at targeting populations and resources to move "step-by-step" towards universal coverage.

Senator Edwards. The Edwards plan has as its primary focus covering all children (Figure 9). Parents would be required to insured their children, assisted by tax credits for employer insurance and an expansion of CHIP. In addition, the plan would expand Medicaid / CHIP to 100 percent of poverty for adults, with a sliding scale premium to 250 percent of poverty. It would provide new options for young adults and create a purchasing pool and tax credits for small businesses to encourage them to offer coverage. And, it would allow people ages 55 to 65 years old to buy into Medicare. The plan also outlines cost containment and quality improvement ideas. The Edwards plan emphasizes the responsibility of government and parents to provide health insurance to all children as the first priority in health reform.

COMPARISONS

To compare and contrast these proposals, this paper juxtaposes them based on their delivery system approaches, financing mechanism, goals, costs, and other priorities. This is neither an exhaustive nor a complete list of points of comparison. Given the goal of proving a snapshot of the plans, it excludes important elements like how eligibility is simplified to ensure maximum participation in the new and existing options. For the same reason, what is included is described at a very simplistic level. The comparison aims to build a framework for understanding the large number of multi-faceted plans.

Where Do The Uninsured Get Coverage?

The proposals would insure the uninsured through different types of health insurance options (Figure 10). The Bush plan would build on the individual market; the Gephardt plan would build on job-based coverage; and the Kucinich plan would rely on Medicare not just for the uninsured but for all Americans. The Edwards plan would focus on existing public and private insurance options to insure children, low-income adults and the near elderly. The other proposals would, in addition to building on existing public and private insurance options, create a new health option for those lacking access to group coverage today. The Dean, Kerry, Clark and Lieberman plans would all model this new option on the Federal Employees Health Benefits system.

It is interesting to note the contrast in the approaches. The Gephardt and Bush plans rely predominantly on existing private options; the Kucinich plan on an existing public program, and the Edwards plan on existing public and private options. The other plans implicitly acknowledge weaknesses in the ability of existing options to help groups like workers in small firms or people with weak attachments to the labor force. Rather than requiring them to offer coverage or sending such workers to Medicare or the individual market, they create a new purchasing pool that provides private health insurance on a group basis to participants.

How Is Affordability Improved?

The plans use a wide range of tools to make health insurance more affordable for Americans, particularly those who are uninsured. They can be classified under three broad headings: tax credits to individuals, subsidies to insurers or employers, and subsidies through public programs (Figure 11). All reform proposals except for Kucinich's would provide some type of advancable, refundable tax credit directly to individuals to reduce their payments for health insurance. Only the President's plan would cap the value of the tax credit (at $1,000 for individuals, up to $3,000 for families) rather than letting its value vary based on actual premium costs. This cap is intended to encourage individuals to shop for efficient plans and limit the "moral hazard" associated with an uncapped subsidy. In contrast, the Edwards and Clark plans' tax credit for children's coverage and the Gephardt plan's tax credit for low-income families are set as a percent of premiums, so that their value automatically adjusts for premiums in high cost areas or for sicker, more expensive people. The new group options in the Kerry, Dean and Lieberman plans would include a tax credit for their premium costs that exceed a set percent of income (from 6-12%). The structure of the tax credits matters: a capped credit tends to help low-cost people, while a tax credit for excessive premiums benefits higher-cost and lower-income people.

A second set of subsidies would reduce peoples' premium costs indirectly, by subsidizing employers and insurers. The Gephardt plan finances coverage almost entirely through a 60 percent tax credit to employers for their premium costs. Employers will presumably pass along this subsidy to workers by having them pay a lower share of the premium (or through higher wages). Small businesses with low-wage workers would also receive assistance under the Kerry and Edwards plans. In addition to employers, insurers would receive subsidies under the Kerry plan in the form of reinsurance for high-cost enrollees. The Dean, Clark and (to a lesser extent) Lieberman plans use Federal funding to stabilize premiums for their new group options, allowing individuals to purchase coverage at rates reflecting the whole population, not just participants, limiting adverse selection problems.

Finally, all plans except for Bush's would expand access to low/no premium health insurance through public programs. Generally, these expansions build upon the existing Medicaid and CHIP benefits, financing and delivery systems. Medicaid charges eligible individuals no premiums and nominal cost sharing, while CHIP allows for premiums and cost sharing that do not exceed 5 percent of income. Several of the plans would allow "buy-ins" to Medicaid / CHIP, raising the premiums charged to participants as eligibility extends up the income scale. The Kucinich plan would move all Americans into Medicare, and the Edwards and Gephardt plans would allow people ages 55 to 65 to buy into Medicare.

How health insurance subsidies are delivered matters since it affects both uninsured people's interest in and ability to purchase coverage and employers' willingness to offer coverage. For example, a Federal subsidy to reduce monthly premiums via an employer or public program may increase coverage more than the same subsidy provided as an end-of the-year tax refund. That said, advancing the tax credit so it accessible on a real-time basis could lessen this difference.

Who Is Targeted for Assistance?

Arguably, the most complex parts of the proposals are their eligibility rules for the various new coverage and financial assistance options (Figure 12). Beginning with those with the broadest eligibility rules, the Kucinich plan targets all Americans in the same, single-payer proposal. The Gephardt plan focuses on all workers, creating affordable insurance through jobs. The Kerry plan has open access to its new group option for all individuals and firms, although its subsidy system is somewhat complicated. The Dean and Lieberman plans are similar in who is allowed access to their new group option, but the Dean financial assistance system is simpler and less targeted than that of the Lieberman plan. The Clark plan allows only individuals without access to job-based coverage into the new pool and has a fairly simply financial assistance piece that targets low-income individuals. The Edwards plan's primary target is children, although it, too, extends coverage to low-income adults, young adults, the near elderly and small businesses. Compared to the Lieberman plan, Edwards' eligibility for its assistance is narrower but simpler. All plans but Kucinich's and Bush's also include a tax credit for continuation coverage (COBRA) for the temporarily unemployed. Finally, the Bush plan has the most restrictive eligibility rules, targeting low-income people who are not eligible either for public insurance or job-based coverage.

Decisions about which group of uninsured and vulnerable Americans to target in health reform may be motivated by a number of goals, from expediency (e. g., the unemployed tax credit targets an easy-to-find, largely uninsured group) to equity (e.g., providing the same level of assistance to all those in a certain income or age group, irrespective of current access to health coverage). Decisions also could be motivated by cost: there is clearly a correlation between the expansiveness of eligibility and new budget costs. This stems from the inconsistent and gap-ridden coverage system that exists today. Eliminating the current inequities and creating a progressive, seamless system of financing itself would be costly, even without extending assistance to cover the uninsured.

Even if every uninsured individual were made eligible for assistance, proposals could fail to achieve their goals if the subsidies themselves are inadequate. The Kucinich plan probably would provide the most generous premium subsidies, although this is not spelled out in the campaign documents. The Gephardt plan would provide generous across-the-board assistance with its tax credit of 60 percent of employer health insurance costs. On the public program side, the proposals generally would maintain Medicaid / CHIP premium structure for children, with the exception of the Lieberman plan, whose Medikids program would run parallel to these programs but would likely replace them over time. For adults, the plans have different points at which both premium payments begin and the public program option is transitioned into tax credits for private insurance options. This ranges widely, from no public program option for childless adults in the Gephardt plan, to covering all families with income up to 185 percent of poverty in the Dean plan, to subsidizing children in employer plans or CHIP in families with income up to 500 percent of poverty in the Edwards and Clark plans. The Clark plan's assistance is extended to similar groups of people as the Edwards plan, but covers a larger share of premiums for eligible individuals. The Bush plan phases out at fairly high income thresholds ($30,000 for a single person and $60,000 for a family) but covers a relatively low percentage of premiums for those eligible. Since the majority of the uninsured have low income, each plan's generosity and extent of eligibility for assistance would have a major impact on its effectiveness at moving towards universal coverage.

Does It Provide Universal Coverage?

Although numerous goals motivate national health reform, one generally comes to mind first: does the plan provide universal coverage to Americans? Universal coverage generally means that all individuals actually receive health insurance coverage. Only Representative Kucinich (and Ambassador Moseley Braun and Reverend Sharpton) make health coverage an enforceable right for all people in the U.S (Figure 13). The Edwards and Clark plans do so for children, requiring parents to provide health insurance for them in existing and new options created by his plan. The Gephardt plan includes a requirement, but for employers to offer coverage, not for individuals to obtain it. This would significantly improve access to health coverage but would not achieve universal coverage.

The Kerry, Dean, and Lieberman plans do not include requirements that individuals obtain health insurance, but create options and systems to move towards universal coverage. The Kerry plan would provide an affordable health insurance option to all Americans, including those whose firms buy them into the new group health option. The Dean, Clark and Lieberman plans would

allow, at a minimum, all those that lack access to job-based coverage to purchase coverage through the pool. This effectively provides access to all those who lack it now. These plans generally structure their enrollment systems like Medicare's voluntary Part B program that has 99 percent participation among those eligible for it. Coverage would not be required but system changes are designed to maximize enrollment. The Bush plan is a targeted policy that does not address the goal of universal coverage.

How Are Health Care Costs Addressed?

Who is eligible and how health insurance is delivered and financed largely determine each plan's costs. Although discussing the budget costs of these proposals is beyond the scope of this paper, it is safe to say that the lower bound is that of the President's tax credit proposal, which is estimated to cost $89 billion from 2004-13.[13] Given that other proposals would cost much more than this, the question of how costs are addressed arises (Figure 14). Generally, the plans are vague about how they plan on addressing the new costs caused by the reform plans. Kucinich is most specific, proposing a phased-in 7.7 percent payroll tax to both fund the new program and replace the current tax exclusion of employer-sponsored insurance. The Clark plan, in its budget plan, includes $125 billion over 10 years in Federal health savings, and gives examples of how those could be achieved. All of the other plans specify that the new Federal costs would be offset by repealing part or all of the 2001 tax cut law. The Kerry and Edwards plan list a number of cost containment policies that would be included in their overall plan, described below. The President has not specified a funding source for his tax credit proposal.

The issue of health care costs is addressed explicitly by the Kerry, Clark and Edwards plans and, to a lesser degree, by the Lieberman plan. These plans generally target prescription drug cost growth as a source of savings, proposing ideas such as increasing access to generics and price information and decreasing the volume of direct-to-consumer advertising. The use of technology in prevention and managing disease as well as reducing costly medical errors and administrative costs is emphasized. The Clark plan would create a commission that, among other tasks, would provide comparative information on the cost effectiveness of alternative therapies, aimed at helping public and private purchasers of health coverage make better, more efficient decisions. The Edwards plan mentions reducing health care fraud and overpayments, and several of the plans lay claim to cost savings due to a simplified, more rational coverage system in the U.S. The plans generally do not put a price tag on the savings from health care cost containment and, indeed, it is not clear that they would cover a large percentage of the new costs of the plans.

Other Priorities

This paper has focused almost exclusively on the health insurance delivery and financing structure as the target of health reform. However, important components of the system and its problems are not addressed here, or are not addressed by the plans themselves (Figure 15). One that is linked to the effectiveness of the plans in covering the uninsured is the role of automatic enrollment systems. Experience in Medicare and Medicaid / CHIP as well as private pension policies suggests that simply making transitions in coverage seamless could make a meaningful difference in reducing the number of uninsured. Drawing on this, most of the plans include policies that would automatically enroll people in coverage options and otherwise simplify the

systems. Another central component of several of the plans is quality. In particular, the Kerry, Edwards, Clark and Lieberman plans include a number of well-established as well as innovative ideas to promote quality. Other topics addressed in the plans, but not in this paper, include medical malpractice reform, increasing biomedical research and the use of evidence-based medicine, strengthening the health care safety net, and improving states' health financing.

The reform plans are also notable in what aspects of the health system they do not address. Perhaps because of the controversy over it in the last reform debate, the minimum benefits package that health insurers would cover is not addressed in the range of reform plans. The Clark plan creates a process for justifying coverage decisions as an alternative to item-by-item benefit mandates. Several plans propose increased coverage of preventive benefits and mental health parity. Few to none address public health infrastructure, HIV/AIDS policy, global health or reducing racial disparities in health. In addition, the health and long-term care needs of people with disabilities and the elderly are left largely untouched.

DISCUSSION

Several aspects of the current debate bode well for the prospects of health reform. First, it appears that there is widespread acknowledgment that the lack of health insurance for 44 million people is a problem. The health and economic consequences of the uninsured have been well documented in the last decade, yielding greater consensus and a higher platform from which to begin the debate. In addition, there is a universal acknowledgement that affordability is a serious problem and that available Federal resources should be targeted to the low-income uninsured. This is most clearly seen in the President's plan. Rather than proposing Medical Savings Accounts or tax deductions to increase coverage, the President's budget includes refundable tax credits targeted to low-income Americans as his vehicle for addressing the problems. And, rather than there being widely disparate proposals from the Democratic candidates for the Presidency, they share a number of common elements, including: a dedication of significant resources to improve health insurance's affordability; reliance on group rather than nongroup health coverage options; and adoption of hybrid systems that build on current public and private insurance options. Irrespective of one's views on this common denominator, the fact that it exists suggests a convergence of ideas that did not exist in the previous health reform debate.

However, the progress in the thinking and convergence of ideas does not mean that there will be an agreement over health reform in 2004. When, in the spring, one Democratic candidate is running against President Bush, the already-sharp differences will be highlighted. These are likely to occur along several fault lines. First, what aspect of health reform will be emphasized: is it coverage or is it cost? As premium growth continues to rise, this issue may surpass coverage as the most important problem. Second, the disagreements between Republicans and Democrats over public versus private and group versus individual insurance will likely persist. Third, the use of capped tax credits, likely called "vouchers," will be contrasted with the use of public programs, likely called "big government bureaucracy." Again, this is not a new difference, but is one that has not yet been resolved. And finally, the question of universal coverage will be raised. It is not yet clear how the final Democratic candidate and the President

will respond. The election of 2004 thus promises to test the candidates' as well as the public's vision and support for health reform.

Notes and References

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