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AN ANALYSIS OF THE OBAMA HEALTH CARE PROPOSAL

John Holahan and Linda J. Blumberg

SUMMARY

OVERALL ASSESSMENT

Our general assessment of the Obama plan is that it would

- greatly increase health insurance coverage but would still leave about 6 percent of the non-elderly population uninsured, compared to 17 percent today.
- substantially increase access to affordable and adequate coverage for those with the highest health care needs, including those with chronic illnesses, by spreading health care risk broadly;
- significantly increase the affordability of care for low-income individuals; and
- reduce the growth in health spending through a broad array of strategies.

In short, Obama's proposal contains the basic components necessary for effectively addressing the most important shortcomings of the current health care system, that is, limited coverage, inadequate risk pooling, and high-cost growth.

Coverage

Senator Obama suggests a new framework—the National Health Insurance Exchange (NHIE)—by which individuals without access to Medicaid, SCHIP, or employer-sponsored insurance could obtain coverage. Obama's plan would reach almost all children and more than half of uninsured adults (in 2007, there were 8.9 million uninsured children and 36.1 million uninsured adults) by

- extending eligibility for Medicaid and SCHIP,
- providing income-related subsidies for coverage in the NHIE, and
- offering a guaranteed source of purchasing insurance coverage, even to those in poor health.

A significant number of other Americans (about 5 million) would also be added to the ranks of the insured by requiring employers to automatically enroll their workers in employer-based health plans and permitting workers to opt out, as opposed to today's system in which workers must actively choose to participate.

Risk Pooling

The Obama plan would clearly increase risk-sharing, or risk pooling, by

- prohibiting insurance companies from using health status to determine price or deny coverage,
- making comprehensive benefits available to all through the NHIE, and
- using broad-based sources of revenue to finance health insurance subsidies, thus guaranteeing that all taxpayers, not just those voluntarily deciding to purchase coverage, share in the costs of providing medical care.

Cost Containment

Senator Obama's plan provides a number of cost-containment incentives, including

- spending $50 billion over several years to accelerate the adoption of electronic medical records and other efficient health information technology,
- creating the NHIE framework, which would result in increased insurer competition,
- repealing the ban on direct price negotiation between Medicare and drug companies and ending the overpayment of Medicare Advantage plans, and
- investing in public health and prevention, expanding chronic care management, and supporting an independent institute to conduct comparative effectiveness analyses on technologies and treatment options.

The plan's architects believe that they could save about 8 percent of health spending in these ways. We agree that cost containment must be pursued on multiple fronts, and, if pursued aggressively, they would eventually achieve savings of the magnitude they envision.

OUTSTANDING ISSUES

Despite the positive aspects of the Obama's plan, there are a few significant concerns.

- While this plan would significantly increase coverage, it would still leave about 6 percent of the non-elderly population uninsured. As a consequence, the inefficient and costly safety net system we have today will need to remain in place.
- The approach relies on an employer mandate, which could increase costs to some businesses and engender the same political opposition that has contributed to the defeat of past reform efforts.
- The campaign's cost estimates ($65 billion) may be somewhat low, even if the campaign's cost-containment initiatives are successful. Much depends on details that are unspecified, including subsidy levels, benefits, reinsurance, and a phase-in schedule. How these are resolved will have significant implications for program costs.

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John Holahan and Linda J. Blumberg[1]

Senator Barack Obama has proposed a health reform plan that would significantly expand coverage and contain health care costs.[2] The plan would expand Medicaid and the State Children's Health Insurance Program (SCHIP) for low-income children and adults and would provide a set of income-related subsidies to help individuals purchase coverage. There would be a requirement that all children obtain insurance coverage (i.e., an individual mandate), but the requirement would not apply to adults. Children's coverage could be obtained through public or private insurance plans.

The Obama plan would ensure that every American citizen had a guaranteed source for purchasing or otherwise obtaining health insurance coverage, a situation that does not exist in the vast majority of states today. While many details have yet to be specified, such as the level of the Medicaid/SCHIP expansions and the premium subsidy schedule, every indication from the campaign suggests that the insurance benefits made available at income-related premiums would be consistent with typical employer-sponsored insurance plans available today. The level of funding proposed, combined with a clear commitment to providing subsidies that are highest for the low income and decline as income increases, indicate that resources will be targeted to those least likely to purchase coverage without assistance. Such an approach provides the greatest increase in coverage per government dollar spent.

The plan would establish a National Health Insurance Exchange (NHIE) through which individuals without access to Medicaid, SCHIP, or employer-sponsored insurance could purchase coverage. Small businesses could also use the Exchange to purchase coverage for their workers, instead of buying it independently. The NHIE would offer a number of private plans as well as a new public plan option. All insurers, both inside and outside the NHIE, would have to offer coverage on a guaranteed issue basis and would be prohibited from rating based on health status. Participating insurers would have to offer coverage at least as generous as the new public plan. Obama also includes a reinsurance proposal that would reimburse employer health plans for a portion of the costs associated with catastrophic health care expenses, subject to a guarantee that insurers will reduce premiums to employers and workers as a result of the subsidy.

Medium and large employers would be required to either contribute meaningfully to the cost of insurance coverage for their own workers or pay a payroll tax as a contribution toward the financing of health insurance for the modest income. The campaign has yet to specify the definition of a meaningful contribution or the level of the payroll tax alternative. The plan would require that employers offering coverage to their workers automatically enroll all workers in their plan, but allow their workers to opt out if they desire. This is similar to the type of provision that many firms use to encourage participation in retirement plans and has been shown to increase overall participation; the default is participation, or opting in, as opposed to opting out. Small firms would be exempt from these requirements and would be eligible to receive tax credits to offset up to 50 percent of the costs of providing coverage to their workers.

The Obama proposal offers various cost containment incentives. His plan proposes to spend $50 billion over several years to accelerate the adoption of electronic medical records and other health information technology. The plan would promote a model of strengthened insurer competition through the NHIE. It would develop policies to improve prevention and to manage

chronic conditions. It would repeal the ban on direct price negotiation between Medicare and drug companies, allow for drug re-importation, and reduce current payments to Medicare Advantage plans. It would invest in public health and prevention, reform medical malpractice, and support an independent institute to conduct comparative effectiveness analysis on technologies and treatment options.

While some of the details are still missing from this plan, the Obama approach clearly signifies a substantial commitment of federal resources to making affordable and adequate health insurance coverage available all U.S. citizens. The financial resources would be dedicated largely to people with low and modest incomes and to small employers, those with the lowest rates of insurance coverage today. The plan would, through the NHIE, provide a guaranteed source for purchasing insurance coverage, and it would prohibit price discrimination in health insurance by health status, spreading the costs of those with the highest health care needs more broadly across the population. The NHIE framework generally, and the public plan option in particular, provide conditions that can be used for increasing the level of competition in the health insurance marketplace. The Obama proposal would also dedicate financial resources to developing the types of health information systems and comparative effectiveness data that could make the delivery of medical care more efficient and higher quality over time. In general, the Obama plan approaches cost containment on multiple fronts because most individual initiatives by themselves have only small effects.

By and large, the proposal contains the basic components necessary for effectively addressing some of the most important shortcomings of the current health care system. We do, however, have a number of significant concerns. First, the approach cannot achieve universal health insurance coverage without an individual mandate for adults; consequently, while this plan would increase coverage significantly, it would still about 6 percent of US residents uninsured (compared to 17 percent today). Because there would be uninsured remaining, including the undocumented noncitizens who are not covered by the approach, the plan will not be able to fully tap into existing safety net funds to help with financing. Second, the approach relies on an employer mandate, which will increase costs to some businesses and engender the same political opposition that has contributed in the past to the defeat of other reform efforts. Third, it leaves several key details unspecified (e.g., new eligibility levels for Medicaid and SCHIP coverage, the subsidy schedule, out-of-pocket payment limitations), and these choices can greatly affect coverage, equity, and costs. Finally, the cost estimates are likely a bit low, but much depends on how the details are resolved. The plan could benefit from considering caps on, but not the elimination of, the exclusion of employer health insurance contributions from taxation as a source of revenues.

Coverage and Affordability

The Obama plan would substantially expand coverage by extending Medicaid and SCHIP and by providing income-related subsidies for coverage in the NHIE. The campaign materials do not specify how far Medicaid and SCHIP would be extended nor do they indicate what if any steps the plan would take to increase participation rates in those programs. A possible scenario is that the plan would extend Medicaid to all members of families with incomes that are below 100 percent of the federal poverty level (FPL) and that SCHIP would be extended to all children age 18 and under up to 300 percent of FPL. The plan would reach close to universal coverage of children (excluding undocumented children), assuming compliance with the mandate (enforcement mechanisms have not been specified). The plan would also provide income-related subsidies, with the government presumably paying the difference between the premium for a standard plan offered in the NHIE and a percentage of family income. The percentage of income cap would increase as income rises. But again, it is difficult to judge the effectiveness of these subsidies without knowing the specific schedule and plan specifications (e.g., any services excluded, cost-sharing, out-of-pocket maximums).

The more generous the subsidies and the more comprehensive the benefits, the more extensive will be the coverage expansion. Agreeing on a subsidy schedule can be difficult. For example, in Massachusetts there was considerable debate over defining what was to be considered affordable for families of different types, the health benefits that would be provided at subsidized rates, and the extent to which the state would subsidize coverage in order to make it affordable.

Research evidence suggests that the Obama approach would cover about half the uninsured adults and almost all uninsured children[3]—there were 36.1 million uninsured adults and 8.9 million uninsured children in 2007.[4] If the Obama plan provided fully subsidized comprehensive coverage to individuals and families below 150 percent of FPL, and introduced modest cost-sharing requirements and increased premiums in steps to roughly 12 percent of income between 300 and 400 percent of FPL, research evidence suggests that voluntary participation would reach about 50 percent of the uninsured.[5] The mandate for children and various other strategies for increasing outreach and enrollment could increase voluntarily participation somewhat beyond that, perhaps to 60 or 70 percent of the eligible uninsured. Less generous subsidies and/or benefits would lead to lower voluntary participation rates. In a preliminary analysis, The Tax Policy Center assumed a subsidy schedule of their own design that would result in subsidy costs close to those projected by the Obama campaign.[6] The schedule they used would lead to relatively high caps on premiums relative to income—6 percent for those between 150 and 200 percent of FPL and 12 percent for those between 250 and 300 percent of FPL.

The Tax Policy Center projected that the Obama plan, based on their assumptions about subsidies and covered benefits, would reduce the number of uninsured Americans by about 18 million in 2009 (because of lower initial participation) and 30 million in 2013.[7] The reasons many Americans would remain uninsured are the high premium requirements assumed by the Tax Policy Center and the lack of an individual mandate. If the subsidy schedule is in fact more generous, coverage would increase, but so would program spending.

The Obama plan compensates for the lack of an individual mandate to some degree by requiring employers to either provide coverage or pay a payroll tax, and by requiring firms that offer coverage to automatically enroll all workers. Workers who do not want to participate in their employer's plan would then have to actively opt out of it. Currently, workers opt in to employment-based coverage instead of being presumed to participate. These provisions could result in higher levels of participation in employer plans and reduce the uninsured by roughly another 5 million people.[8]

The Sharing of Risk

The Obama plan would increase the regulation of insurance markets. The central purpose of insurance is to pool risk, thereby protecting individuals from large financial losses and providing financial access to medical care when it is needed. The more similar the individuals in a particular insurance pool are, the less risk spreading takes place; the more diverse the health status of the individuals in an insurance pool, the broader is the sharing of risk. Broader risk sharing leads to savings for those with higher expected health care needs, but at the expense of higher costs for those not expecting significant use of medical services.

Insurance regulation is intended to increase the pooling of risks and minimize risk segmentation. Risk segmentation can be achieved by separating individuals of differing risks into different health insurance products, denying coverage outright or limiting the benefits offered to higher-risk populations, or allowing price discrimination within the same products according to health status. Greater segmentation will tend to make medical care less accessible for many with serious health care needs, either because coverage is denied or the financial costs are too great. Attempts to broaden risk pooling in voluntary health insurance markets brings its own complications; for example, when healthy individuals faced with premiums that exceed their expected costs decide to go without insurance. This is turn increases premiums for those with coverage.

The Obama proposal would clearly increase risk sharing or risk pooling in several ways. First, the plan would prohibit insurance plans from denying coverage to applicants based upon their health status. Only four states' private nongroup health insurance markets currently prohibit insurers from denying health insurance coverage to individuals due to their current or past health status or experience.

Second, coverage would be available through a new purchasing pool, the National Health Insurance Exchange, which would make benefits similar to those now offered through the Federal Employees' Health Benefits Plan available to all applicants. The result is that the costs of medically necessary care would be spread broadly across all insured individuals.

Third, having premiums and cost-sharing responsibilities set at levels that are related to ability to pay leads to a similar broadening of risk pooling. When individuals' purchase coverage with lower premiums but high deductibles and other high cost-sharing requirements, a greater share of medical care falls upon those who are the greatest users of care, those with significant medical needs. The greater the cost-sharing for the users of medical services, the less the healthier insured population shares in the cost of care for the unhealthy. Providing income-related premiums for all low-income individuals, as Obama proposes, will tend to increase insurance coverage for the young and healthy, as they have high rates of uninsurance and also have a higher than average likelihood of being low income.[9] Bringing healthier individuals into insurance pools this way will help to balance off the higher costs of those that gain coverage from the new rules that guarantee access to all plans regardless of health status.

Fourth, the approach would use broad-based sources of revenue to finance subsidies within the insurance exchange as well as a Medicaid/SCHIP expansion. These broad-based revenue sources ensure that the costs of providing health insurance do not just fall upon those voluntarily participating in the insurance pool.

Finally, the plan includes a mandate that all children be enrolled in health insurance coverage. Under a mandate, the healthy do not have the option to stay out of insurance pools, segmenting themselves from the unhealthy and not contributing to insurance premiums.

Several Risk Sharing Issues Remain

Because the individual mandate does not include adults, some healthy adults will decide to opt out of insurance coverage in order to avoid paying premiums that reflect a diverse risk pool. While income-related subsidies will help partly offset this dynamic, it is unclear how much higher the average health care costs of those with insurance will be compared with those without insurance. In addition, the Obama plan does not explicitly discuss spreading of risk across insurance plans in and/or outside the NHIE because some plans attract enrollees with higher than average health care risks. Although income-related subsidies will help limit the exposure of the modest income to high premiums due to adverse selection, there may still be a need to risk-adjust premiums across insurance plans because of differences in risks.

The Obama plan includes a proposal for government-sponsored reinsurance, although, again, details of how it would work are not available. The intent of this type of policy is to more broadly spread the costs associated with insuring high-cost individuals. However, in our previous research, we examined a number of government-financed reinsurance policies, including ones that would have the government pay 90 percent of insurer costs after an individual incurred medical expenses of $35,000 or $50,000 in a year. We found reinsurance with such high thresholds (those most often discussed) would be very costly and have only a limited effect on lowering private insurance premiums.[10] Depending upon how it is structured, reinsurance could significantly add to the government cost of the Obama plan while having little impact on voluntary insurance coverage decisions. We have found that reinsurance with such high thresholds does not address the risk-sharing issues associated with the chronically ill, but rather unexpected episodically high costs. The insurance industry seems well equipped to deal with the latter, but less so the former.

Cost Containment

The cost-containment features of the Obama plan are extensive,[11] including most of the reforms that are commonly advocated. These include the development of a comparative effectiveness research program to identify effective new technologies and treatment options, accelerating the adoption of health information technology, expansion of care coordination for the chronically ill, and efforts to reduce smoking and obesity. The program would also have the government negotiate with pharmaceutical companies to reduce the price of Medicare prescription drugs, implement other payment reforms within Medicare, and reduce payments for Medicare Advantage plans. Most reforms that the Obama plan envisions have some potential to contain costs, though there is more evidence on some than others. Most of the savings from each initiative are probably small, on the order of .5 to 1 percent of health care spending each.[12] But taken together, the savings could become significant.

But these cost-containment initiatives can only be successful if they are aggressively pursued. While the various initiatives differ in the mechanism used to control costs, several can be successful only if they reduce revenues of hospitals, physicians, or pharmaceutical and medical device manufacturers. For example, interoperable electronic medical records partly achieve savings if they reduce duplication of tests and other services, with these reductions lowering provider revenues.[13] The same is true of more efficient management of care of the chronically ill,[14] lower drug prices, and evaluating the cost-effectiveness of new technologies and reimbursing for the most cost-effective treatments.[15] Consequently, aggressive cost-containment initiatives virtually guarantee concentrated resistance on the affected part of the provider community. But we believe pursuing cost containment through multiple approaches is the best and perhaps only strategy likely to be effective.

The Obama plan would also have a public plan that would compete with insurers within the health insurance exchange. A public plan could be a strong player in the market and have strong negotiating power with providers; for example, Medicare has clearly had some success in restraining hospital and physician payments.[16] The public plan would compete actively with other insurance arrangements. To the extent that the public plan that was offered was an attractive product and could contain costs because of its bargaining power with providers, other insurers would have to compete more aggressively than they do today. We believe this is an essential part of this plan because of the lack of true competition in a large number of U.S. health care markets as a result of extensive provider consolidation.[17] This consolidation, particularly among hospitals, has resulted in serious constraints on the ability to contain costs.[18]

As we have written elsewhere, we do not believe a public plan would dominate the market and drive out private competition, but we do believe it could have a great influence on this market.[19] The public plan is unlikely to use all of its market power, as Medicare does not, because of political pressures and caution regarding the ability to maintain access to a high-quality health care system. But a public plan and the competition it would engender could certainly lead to savings relative to the current system. In our view, today, insurers are either unable or unwilling to use market power to constrain rates of payment to dominant hospital or physician systems. The public plan would provide the countervailing power the market needs. Those insurers that could contain costs either through their ability to bargain with providers or to develop innovative cost-containment approaches that would contain health care use could survive. Integrated health systems would be advantaged in a more competitive marketplace because of their inherent efficiencies.

The Obama campaign has argued that their plan can save $2,500 per family, or about 8 percent of health care spending.[20] Such savings would accrue in part to the government and in part to the private sector (employers and individuals). We believe that the potential exists for all these initiatives together, including a well-managed public plan as a competitor in the marketplace, to achieve savings of at least this magnitude, assuming they are willing to pursue these initiatives aggressively even in the face of provider resistance. However, we note that many

of these initiatives will take several years to be fully effective.

The Employer Mandate

The Obama plan would require employers above a certain size to provide coverage meeting defined standards or pay a payroll tax that would be used to help finance the reforms. Employers that offer health insurance coverage would be required to sign up their workers automatically but allow them to opt out if they do not want to enroll in coverage. The intent is to build upon the current employer-based system and take advantage of its inherent advantages in group purchasing and risk pooling. These provisions are likely to increase coverage, imposing only the cost associated with the current tax exclusion for employer sponsored insurance payments on the government. Both the employer mandate and the automatic enrollment provision would increase costs to business and would most assuredly guarantee intense business opposition.

Most goals of the Obama plan could be achieved without an employer mandate. In fact, recent evidence from Massachusetts indicates that employer coverage actually increased in response to the combination of an individual mandate and a very small assessment on employers who did not provide coverage, even in the presence of substantial subsidized public coverage for those below 300 percent of FPL.[21] Most employers currently do provide coverage, and with no other policy changes, most are likely to continue to do so. The tax benefit to workers from obtaining insurance coverage through their employers is one of the important reasons why most coverage is obtained this way, and the Obama approach would do nothing to change that incentive.

Financing

The cost estimates that have been provided by the campaign are probably somewhat optimistic. The Obama campaign estimates net expenditures—the cost of coverage expansion and subsidies for health information technology and other cost containment strategies less the savings resulting from these initiatives—to be about $65 billion. The Tax Policy Center estimates the plan to cost $86 billion in 2009 (because lower initial participation) and $160 billion in 2013, but these estimates do not account for cost-containment impacts that are included in the campaign's estimates.[22] The estimates seem reasonable based on our assumptions of how key details would be addressed. One reason is that, unfortunately, the plan is likely to cover only about half or somewhat more of uninsured adults, while it would cover almost all children. This lowers costs but not by as much as might be expected because those who enroll will tend to be those with the greatest health care needs. The plan's costs also depend greatly on the subsidy schedule. To achieve a high level of voluntary enrollment, the subsidies will have to be fairly generous. If the subsidy schedule is more generous than assumed by the Tax Policy Center, coverage would be greater, but so would the cost of the plan to the government. We also believe that attacking the cost-containment problem on multiple fronts is the correct approach and that most of the savings the campaign envisions are achievable over time if pursued aggressively.

With a significant population remaining uninsured and the fact that the plan does not intend to cover undocumented immigrants, the Obama plan will be unable to redirect much of the current safety net dollars already supporting health care toward financing reform. There is a considerable amount of money currently supporting the uninsured, though it is used quite inefficiently.[23] These funds include Medicaid and Medicare Disproportionate Share Payments and payments made by the Veterans Administration, the Indian Health Service, and state and local governments. It will be difficult to use a significant amount of these funds to support coverage expansion in the Obama plan since providers will argue strongly that they need to maintain these dollars to provide care for the remaining uninsured population.

The Obama plan proposes to pay for a significant portion of its costs by reversing recent tax cuts for those in the top two income tax brackets. There are many other claims on these dollars—for example, rebuilding the military, improving the nation's infrastructure, addressing the problems with alternative minimum income tax, and, when economic conditions improve,

addressing the deficit. An alternative strategy would be to cap the employer tax exclusion for health insurance contributions and then indexing the cap to the growth in gross domestic product (GDP) over time. Capping rather than eliminating the exclusion, would be less destructive to the current employer market.[24] It would also result in substantial revenues that could help pay for the coverage expansion.

Conclusion

Our general assessment of the Obama plan is that it would greatly increase health insurance coverage but would still leave about 6 percent of non-elderly US residents without insurance. The plan should receive high marks for increasing the sharing of health care risk through a combination of strategies that would substantially increase access to affordable and adequate coverage for those with the highest health care needs, including those with chronic illnesses. The plan would make great strides in increasing the affordability of care for the low-income population.

The cost-containment initiatives in the plan have the potential to reduce cost growth if aggressively pursued. The fact that the Obama plan would devote $50 billion to help subsidize the adoption of health information technology suggests a seriousness of intent. However, an aggressive pursuit of several of these measures would likely be met by opposition from affected providers, including hospitals and pharmaceutical manufacturers. Further, the savings from many of the cost-containment provisions could take a number of years to materialize.

On the other hand, the approach includes an employer mandate that will almost certainly result in opposition by the business community. The lack of an individual mandate for adults means that the plan would not reach universal coverage, but it could still experience relatively high subsidy costs due to the attraction of higher-cost enrollees into public programs and new subsidized insurance options. The proposed funding is likely inadequate but is probably not far from what is necessary to meet its objectives. The Obama plan does not address the issue of the tax exclusion for employer contributions to health insurance. A cap on this exclusion and indexing it to GDP growth would result in substantial revenues that could help pay for the proposed coverage expansion.

Notes

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