

The Obama Plan: More Regulation, Unsustainable Spending

If the economic incentives that drive spending growth are not addressed, any savings gained through Barack Obama's proposed reforms will disappear.

by Joseph Antos, Gail Wilensky, and Hanns Kuttner

ABSTRACT: The health reform plan put forth by Sen. Barack Obama (D-IL) focuses on expanding insurance coverage and provides new subsidies to individuals, small businesses, and businesses experiencing catastrophic expenses. It greatly increases the federal regulation of private insurance but does not address the core economic incentives that drive health care spending. This omission along with the very substantial short-term savings claimed raise serious questions about its fiscal sustainability. Heavy regulation coupled with a fallback National Health Plan and a play-or-pay financing choice also raise questions about the future of the employer insurance market. [*Health Affairs* 27, no. 6 (2008): w462–w471 (published online 16 September 2008; 10.1377/hlthaff.27.6.w462)]

ONCE AGAIN, HEALTH CARE REFORM is taking a prominent place in an American election. Although concern about the economy has reduced the relative importance of health care for the public—to number three in February and number four in June—the issue remains a serious one for the country.¹ The fundamental problems of cost, quality, and the uninsured are well known. Although there is wide agreement that these are serious concerns, there is less agreement about which problems are more important and what should be done.

The health reform plan put forth by Sen. Barack Obama (D-IL) during the 2008 presidential campaign focuses on expanding insurance coverage, providing a variety of subsidies to individuals and small businesses, and expanding eligibility for Medicaid and the State Children's Health Insurance Program (SCHIP).² It greatly increases federal regulation of private insurance, including what benefits must be offered by all insurance plans, but it does not address core economic incentives

.....
Joe Antos is the Wilson H. Taylor Scholar in Health Care and Retirement Policy at the American Enterprise Institute in Washington, D.C. Gail Wilensky (gwilensky@projecthope.org) is a senior fellow at Project HOPE in Bethesda, Maryland. Hanns Kuttner was, until recently, a senior research associate at the Economic Research Initiative on the Uninsured at the University of Michigan in Ann Arbor. Wilensky is a volunteer adviser to the McCain campaign.

that drive health care spending. The plan does not promise universal coverage, and it does not include a mandate on everyone to purchase insurance, which was central to Sen. Hillary Clinton's (D-NY) plan during the Democratic primary. The one group for whom there is a mandate is children—actually, a mandate on parents to purchase coverage for them or enroll them in a government health program.

We focus on several key features of the Obama proposal: the new National Health Plan (NHP), the national Health Insurance Exchange, the reinsurance subsidy, the “play-or-pay” requirement on larger employers, and the mandate that children be insured. As envisioned by Senator Obama, each of these extends the control of government over health insurance, imposing new requirements that will drive up the cost of insurance unless the savings from other policies that have been claimed by the campaign actually materialize. Moreover, heavy regulation coupled with a fallback NHP could accomplish what Sen. John McCain's (R-AZ) proposal has been accused of: undermining the employer insurance market.

The following analysis reflects the authors' concern that Senator Obama's failure to address the perverse incentives in the U.S. health system will exacerbate the cost problem he has argued must be solved if we are to achieve anything close to universal coverage. Tax subsidies that promote first-dollar coverage have led consumers, health care providers, and suppliers to act as if any service that might yield some value, no matter how small, should be covered. Subsidized third-party payment has helped drive up health spending and, as demonstrated by the *Dartmouth Atlas*, sometimes has even led to poorer health outcomes. Realistic expectations about cost, value, and the outcomes that health care is likely to provide must be better understood by all parties. Senator Obama promises business as usual, albeit with greater regulation intended to impose behavioral changes from the top down. In our view, such a strategy will fail to limit spending growth, will impede useful innovation, and will require more sacrifices in the years ahead.

Because we are working from campaign materials and speeches, many details of the proposal or precisely how it would work are not available. We have thus had to make some assumptions about how the concepts might be implemented.

National Health Plan

The NHP would be made available through the Health Insurance Exchange to anyone who does not have access to employer-sponsored insurance or existing public programs, such as Medicare, Medicaid, or SCHIP. In addition, the NHP would be made available to small employers that do not offer their own plan.

Eligibility for the NHP would be guaranteed for “all comers,” with no exclusions because of pre-existing conditions and no differentiation in premium charges because of health status. People who need financial assistance but who are ineligible for Medicaid or SCHIP would receive an income-related subsidy. Who would qualify and the amount or type of subsidy to be provided have not been specified.

The NHP has been described as being “like the plan available to members of Congress.” Its benefits could be broadly similar to one of the national plans offered under the Federal Employees Health Benefits (FEHB) program, and the cost of the NHP is likely to be about the same order of magnitude.

The most popular FEHB plan, the Blue Cross Blue Shield Standard Option, offers a broad array of medical services with modest cost sharing (including a \$600 deductible and \$15 copayments for doctor visits). In 2008, the full monthly premium charged by that plan was \$1,027.95 for family coverage.³ The federal government contributed \$713.48, and the enrollee paid the remainder.

If the NHP is similar in coverage and cost to the \$12,000 a year Blue Cross plan, the premiums would not be affordable for many families without subsidies that are even greater than the government’s current contributions on behalf of FEHB program enrollees. Families would not be able to purchase less-expensive coverage, since all other insurance would be required to offer benefits at least as generous as those of the NHP (measured on an actuarial basis). This would create a large new entitlement, raising concerns (discussed below) about the fiscal sustainability of the reform.

Senator Obama could reduce the subsidy cost by pegging benefits to a lower standard. In 2008, the lowest monthly premium for a national FEHB plan was \$423.69 (or about \$5,080 a year) for the Mail Handlers Benefit “value option,” introduced for the first time this year.⁴ Although the Mail Handlers plan is less than half the cost of the Blue Cross plan, it requires higher cost sharing (with a \$1,000 deductible and 20 percent coinsurance on hospital and physician services) and tighter limits on benefits. A lower-value plan might be a more feasible standard, but it is probably not what the candidate’s political base thinks he has promised.

Health Insurance Exchange

A national Health Insurance Exchange would offer individuals a choice of health plans, including private plans meeting federal regulations and the NHP. All plans available through the Exchange would be required to offer benefits at least at the level of the NHP, meet quality and efficiency standards, issue every applicant a policy (“guaranteed issue”), and charge the same premium regardless of the enrollee’s health status (“community rating”). Premium increases would be reviewed, and above-average increases would have to be approved by the Exchange.

The Exchange has some similarities with the FEHB program and the Massachusetts Connector but with much heavier regulatory powers. The FEHB program offers several national plans that are open to federal employees and retirees as well as plans available only in specific localities. All FEHB program enrollees receive a subsidy that averages about 72 percent of the full premium. The Massachusetts Connector offers health plans as part of the new law mandating that individuals purchase health insurance. Some enrollees in Connector plans are eligible for low-income subsidies, but others purchase unsubsidized insurance.

“When the choice of benefits becomes a political decision, it is difficult to reduce benefit mandates.”

Although the Exchange could make it easier for individuals to buy their own insurance, it also imposes regulatory requirements on the private market that would drive up insurance costs or distort insurance choices. For example, requiring that all plans offer benefits at least as good as those of the NHP would exclude some plans that are currently available under FEHB program unless the mandated benefit were set equal to the lowest-actuarial-value FEHB plan. A higher benefit standard would ensure better coverage, at least initially, but would also lock in a higher cost structure and reduce the range of insurance options.

Some regulation is needed to ensure the proper functioning of the insurance market. If the taxpayers are to subsidize coverage, that coverage needs to be defined. But the defined coverage needs to consider the costs imposed by greater levels of mandated benefits, and it should be set at a level that is sustainable over the long term. Moreover, we should not preclude individuals from choosing less coverage, as long as we have provided them with the financial means to purchase basic coverage. Allowing choice inevitably opens the possibility of risk selection, but risk adjustment and various kinds of pooling arrangements for high-cost individuals can reduce the adverse consequences without imposing an unaffordable benefit standard on all insured people.

When the choice of benefits becomes a political decision rather than an individual one, it is difficult to reduce benefit mandates or loosen other regulations that can reduce cost. Facing premiums that challenged its notions of affordability, Massachusetts could have allocated more of its budget to subsidies or reduced the cost of mandated benefits. Instead, it chose to widen the “unaffordability” escape clause. In 2007 about 60,000 uninsured people were exempted from the mandate.⁵

It is unclear whether the Exchange’s regulations would apply only to plans that it offers or would be extended to all private health insurance, including employer-sponsored coverage. Some regulations (such as nondiscrimination provisions) already exist for employer plans. We assume that employer plans would be required to offer the same actuarially equivalent benefits as the NHP, to be treated as exercising the “play” option under “play-or-pay.” Setting a high actuarial level would discourage employers from experimenting with new approaches to coverage, cost sharing, and other aspects of insurance design that could increase the efficiency of health care use.

Reinsurance

A relatively small percentage of patients, who are seriously ill and often have multiple chronic conditions, account for a high proportion of the amount spent on health care. Charges for the services they use are factored into health insurance

premiums, raising the cost of coverage for everyone. The Obama plan would reimburse employers for some of the costs incurred by catastrophically ill people covered by an employer's health plan. Such payments, referred to as reinsurance by the campaign, would go to employers that agree to use them to reduce the cost of workers' premiums.

The vast majority of employers who offer health insurance already are protected against unpredictable high costs. Employers that purchase insurance automatically receive this protection, and those that are self-insured usually purchase coverage for catastrophic costs through their third-party administrator. The Obama provision provides little additional protection against the uncertainty of health spending for the private market.

Even though employers would welcome the subsidy, the reinsurance does not reduce health care use or cost. Instead, the policy just shifts some of the cost to the federal budget and could even increase health care spending. Insurers and providers might be encouraged to provide more services to patients who were above the catastrophic threshold since the federal government was sharing in the cost.

The proposal could also lead to anomalous results. One neonatal intensive care stay could lead to federal catastrophic payments for an employer with younger employees (and lower health costs per employee), while an employer with older workers and much higher per employee costs might receive no subsidy for the costs of managing chronic conditions.

A subsidy for catastrophic cost may also result in more detailed federal scrutiny of the employer's health plan. Before subsidizing catastrophic costs, the government will need to establish which costs should count toward meeting the catastrophic threshold, whether the prices paid were appropriate, and whether the services were reasonable and necessary. That would require federal rules that today are unnecessary.

Mandates

Mandates to purchase insurance or pay for someone else's coverage force some people to pay for coverage that they would not willingly purchase on their own. Senator Obama has argued that a universal mandate to purchase insurance would not be sound policy unless insurance costs were brought down. He supports a requirement that employers contribute to the cost of health coverage for their workers and a mandate that children have coverage.

■ **Play-or-pay.** Under Senator Obama's "play-or-pay" approach, employers that do not offer or make a meaningful contribution to the cost of high-quality health coverage for their employees would be required to contribute a percentage of payroll toward the costs of the national insurance plan.⁶ Small businesses would be exempt from this requirement but would receive a refundable tax credit of up to 50 percent of the health insurance premiums they pay.

Play-or-pay is a mandate on employers to pay for their employees' health insur-

ance that allows some flexibility in the way that payment is made. An employer will offer (and contribute to) coverage if the employer can provide some combination of better benefits and lower costs than the national insurance plan. Better health insurance can be an important way for the employer to recruit and retain workers, particularly in a tight labor market. Smaller firms and those in industries such as services that do not generally offer health benefits may be more likely to pay the new health tax than to offer coverage.

An employer mandate is a political expedient that conceals who actually pays for the required benefit.⁷ Economists generally agree that employee benefits ultimately are paid for by the employee. A worker's total compensation depends on his or her productivity to the firm, regardless of the split between wages and benefits. When an insurance mandate is imposed on all employers, the added cost of labor is covered through a combination of lower wages or other benefits or reduced employment. According to one study, 83–100 percent of the cost of coverage is shifted to employees through reduced wages.⁸ A reduction in pay or loss of jobs would occur whether the employer chooses to offer coverage or pay the health tax.

Wages and employment would fall. How much and how quickly depend on the ease with which capital can be substituted for labor and on the price-sensitivity of consumer demand for the products sold by the firm. Low-wage workers are likely to experience a greater loss of job opportunities rather than wage cuts simply because there is less ability to lower their wages over time. Not coincidentally, low-wage workers are also less likely to have health coverage in the first place. The play-or-pay mandate, which is meant to help workers who do not have insurance gain coverage, could instead undermine their chances for economic success.

This is one of the reasons why small firms, which have a larger share of low-wage workers, are exempted from play-or-pay. The proposed tax credit for small employers might encourage some firms to offer coverage, but most small firms that currently do not offer coverage are likely to find an offer to cover half of the additional cost a deal they can refuse.

One of the objectives of the Obama plan is to preserve the employer as the primary sponsor of private health insurance. However, the play-or-pay requirement coupled with the availability of the NHP could have the opposite effect. If the tax payment is low relative to the costs of insurance, employers may decide to “cash out” their insurance contributions and “pay” rather than “play” into the support of the government plan. Similarly, if the “play” standard requires broader or more costly benefits than an employer currently offers or if the firm has an older workforce that uses more health services, the employer may decide that paying the tax is the better choice. Some might argue that this is not the experience that Massachusetts is reporting; however, the Massachusetts spending and coverage expansion experience indicates that the state is clearly still in an early stage of transition to its new plan experience.

■ **Child mandate.** The Obama plan would require that all children have health

insurance. In fact, that is a mandate on parents to pay for private coverage for their children or enroll them in Medicaid or SCHIP. Such a mandate can be difficult to enforce and is unlikely to result in universal coverage for children.⁹ Enforcement mechanisms have not been specified but might include loss of adult benefits (such as the dependent deduction or the earned income credit) for noncompliance or denial of benefits to children, such as admission to public school. However, such policies harm both the children and the parents who fail to obtain the required coverage.

Cost Of The Plan

The Obama approach to health reform promises affordable and generous health insurance for everyone. The goal is to increase dramatically the number of newly covered people and bring costs under control. According to the campaign, the average family would save up to \$2,500 a year as a result of new federal subsidies and proposals intended to slow the growth of health spending.¹⁰ Even then, the campaign says that federal outlays for health care would increase by \$50–\$65 billion annually when fully phased in.

The savings estimates and the resulting impact on federal outlays from the Obama plan are controversial.¹¹ Savings proposals include familiar ideas, many of which are embraced by both candidates: greater use of information technology (IT), improved disease management and care coordination, clinical effectiveness research, and better payment methods. Although many policymakers and experts agree that such policies would improve health system performance, there is little evidence that they can be implemented quickly or effectively and little proof that implementing the policies would yield net reductions in health spending.

The Congressional Budget Office (CBO), for example, has analyzed the likely savings from the adoption of health IT and found that “the adoption of more health IT is generally not sufficient to produce significant cost savings.”¹² In another report, the CBO noted that “initial results from disease management programs and other efforts indicate the difficulty of reducing the use of care.”¹³ In a letter to Rep. Pete Stark (D-CA), the CBO reported that total health spending might be reduced by \$6 billion over the next decade through the use of comparative effectiveness research, of which \$1.3 billion would accrue as reduced federal outlays.¹⁴ Over that period, national health expenditures are projected to total \$32.5 trillion.¹⁵

The CBO's pessimism should not be taken as defeatism. Slowing the growth of health spending has been a priority among employers, insurers, and the government for decades. Numerous attempts have been made to find innovations in payment, delivery, and administration that could accomplish that goal. Nonetheless, over the past forty years, national health spending has grown an average of 2.1 percentage points faster than U.S. gross domestic product (GDP), both measured on a per capita basis.¹⁶ Sizable reductions in this “excess cost growth” within a single presidential term are as unreasonable as they are unlikely.

Advocates of the Obama approach expect the NHP to use its market power and

legal authority to restrain the growth of spending. However, those advantages already exist for the Medicare program, which has not had notable success controlling its spending. Increasing the share of health spending paid for through federal programs does not automatically confer a greater ability to negotiate prices or buy smarter, as Medicare has found in its durable medical equipment spending, and may be particularly problematic in the political climate that will surround the new NHP. The program may be able to dictate prices below market-clearing levels for a time, but whether concerns about a potential loss of access to affected services would occur, driving up prices, is another matter. Most important, prices are only part of the spending equation. As Medicare has demonstrated repeatedly, increases in the quantity and mix of services can cause spending to increase even when prices remain flat.

Any major expansion of coverage will be costly, and the Obama promise of affordability would require new, large, and rapidly growing federal subsidies that are unlikely to be sustainable, fiscally or politically. The size of the new subsidies depends on what *affordability* means. Although the campaign has not defined the term, it is commonly thought of as a limit on the share of family income that goes to health care. Such “affordability” subsidies would be an ever-growing share of the federal budget if health spending continues its upward climb. Since the government would bear the full liability for all health costs exceeding the affordability standard, there would be a strong incentive to continue the behavior that has caused health spending to grow at alarming rates over the past decades.

A Commonwealth Fund proposal demonstrates the potential cost of the Obama reforms.¹⁷ That proposal shares several features in common with the Obama approach, including a national insurance “connector,” required employer contributions toward premiums, and expanded Medicaid and SCHIP. It also has a mandate on individuals to purchase insurance, while Obama would have an explicit mandate only for children. The proposal includes tax credits to offset any premium cost in excess of 5 percent of income for lower-income tax filers and 10 percent of income for higher-income tax filers.

According to its authors, the Commonwealth proposal would increase federal spending by \$162.5 billion if it were operating in 2008. About half of that additional spending would be offset by new taxes on providers and employers and by eliminating federal payments to hospitals serving low-income populations. Over ten years, the proposal could increase federal outlays by about \$1.1 trillion net of savings.¹⁸

In the likely event that other savings from health system efficiencies do not materialize quickly, Congress would face tough choices in meeting budgetary requirements. If Congress does as it has with Medicare, insurers and providers can expect to bear the brunt of the fiscal pressure, with reduced payments for services that fail to keep up with the rising costs of medical care, which ultimately will reduce patients’ access to care.

Improving The Obama Plan

Given the deep concerns we have with key aspects of the Obama plan, it is difficult to suggest improvements that do not also change the focus of the plans' proposals in significant ways. Most important is the plan's failure to correct the inefficiencies and inequities created by the current tax treatment of health insurance. We believe that Senator Obama should limit the open-ended subsidy created by the tax exclusion, ideally replacing the exclusion with a refundable tax credit. An important first step would be to cap the tax exclusion, lowering the cap over time. At the same time, efforts should be made to move ahead with insurance market reforms, including the rules affecting the Exchange, which would allow the individual insurance market to improve its functioning.

Second, the benefits in the NHP should be set at a level that provides high-value coverage and is fiscally sustainable. That almost certainly means a plan that is at the low end of options currently offered through the FEHB program, but it might be lower. The Obama plan should explicitly recognize the resource constraints that face the health system in the years ahead. In addition, it would be highly desirable to have several private plans available that offer coverage nationally as is done with the FEHB program instead of relying on a single monolith whose mistakes could affect an entire health care system.

Third, the Exchange should regulate with a light hand when it sets the basic rules for insurance plans available as alternatives to the NHP. Those rules should not be micro-prescriptive, specifying every feature that needs to be included in every health plan offered in the United States. Finally, there needs to be more honesty about what the public can reasonably expect from the Obama plan. We need a better idea of how many of the uninsured would gain coverage in the near term, how access to health care might change for those who already have insurance, what the plan will really cost, what must be done to slow health spending, and when we can expect to see cost growth bend down. Real reform takes time. Much as we would all like to believe otherwise, there are no quick fixes out there.

THE NUMBER OF PEOPLE WITHOUT HEALTH INSURANCE will not materially decline even if the economy improves, and it could increase sharply if the economy were to fall deeper into a slump. At the same time, health care costs are expected to continue their upward spiral, placing a growing burden on American families. Neither candidate has all the answers to these problems. The critical issue for us is whether they propose to change the underlying dynamics that drive health care costs to continue increasing much faster than the economy, putting the cost of insurance outside the reach of too many American families. We believe that Barack Obama's plan does not. Unless the factors underlying cost growth are addressed, the country will be left with more unsustainable spending, which will ultimately unravel the coverage expansions.

.....
Gail Wilensky is an unpaid adviser to the McCain campaign, but the opinions expressed here are her own and not the views of the McCain campaign or Project HOPE.

NOTES

1. Health08.org, “Kaiser Health Tracking Poll: Election 2008—June 2008,” http://www.kff.org/kaiserpolls/h08_posr062508pkg.cfm (accessed 8 September 2008); and Health08.org, “Kaiser Health Tracking Poll: Election 2008—March 2008,” http://www.kff.org/kaiserpolls/h08_pomr030708pkg.cfm (accessed 12 September 2008).
2. Obama-Biden, “Healthcare,” <http://origin.barackobama.com/issues/healthcare> (accessed 8 September 2008).
3. Includes both the employee and the employer contributions to the premium. The premium amount is for federal employees other than those covered by the postal service. See U.S. Office of Personnel Management, “Non-Postal Premium Rates for the Federal Employees Health Benefits Program: 2008,” http://www.opm.gov/insure/health/08rates/2008non_postal_ffs.pdf (accessed 9 September 2008).
4. This plan is priced low (\$2,780 below its closest national plan competitor) to gain market share, particularly among younger and healthier federal employees. If the NHP adopted a similar benefit package, premiums are likely to be higher since the NHP would enroll a more representative cross-section of people.
5. A. Dembner, “Health Plan May Exempt 20 Percent of the Uninsured,” *Boston Globe*, 12 April 2007.
6. Obama-Biden, “Healthcare.”
7. A.B. Krueger and U.E. Reinhardt, “The Economics of Employer versus Individual Mandates,” *Health Affairs* 13, no. 2 (1994): 34–53.
8. J. Gruber, “Health Insurance and the Labor Market,” chap. 12 in *Handbook of Health Economics*, vol. 1, ed. A.J. Culyer and J.P. Newhouse (Amsterdam: Elsevier Science B.V., 2000), 645–706.
9. S.A. Glied, J. Hartz, and G. Giorgi, “Consider It Done? The Likely Efficacy of Mandates for Health Insurance,” *Health Affairs* 26, no. 6 (2007): 1612–1621.
10. D. Blumenthal, D. Cutler, and J. Liebman, memorandum on the Obama Health Care Plan, <http://www.nytimes.com/packages/pdf/politics/finalcostsmemo.pdf> (accessed 8 September 2008).
11. K. Sack, “Health Plan from Obama Spurs Debate,” *New York Times*, 23 July 2008.
12. Congressional Budget Office, *Evidence on the Costs and Benefits of Health Information Technology* (Washington: CBO, May 2008).
13. CBO, *High-Cost Medicare Beneficiaries* (Washington: CBO, May 2005).
14. Peter R. Orszag, director, CBO, letter to Rep. Pete Stark on comparative effectiveness research provisions of HR 3162, 5 September 2007, <http://www.cbo.gov/ftpdocs/85xx/doc8598/09-05-ComparativeEffectiveness.pdf> (accessed 8 September 2008).
15. The sum of projected national health expenditures from 2008 through 2017 is from Centers for Medicare and Medicaid Services, “National Health Expenditure Projections 2007–2017,” <http://www.cms.hhs.gov/NationalHealthExpendData/Downloads/proj2007.pdf> (accessed 8 September 2008).
16. Weighted average of historical averages for excess cost growth in Medicare, Medicaid, and other health spending computed from CBO, *The Long-Term Outlook for Health Care Spending* (Washington: CBO, November 2007).
17. C. Schoen, K. Davis, and S.R. Collins, “Building Blocks for Reform: Achieving Universal Coverage with Private and Public Group Health Insurance,” *Health Affairs* 27, no. 3 (2008): 646–657.
18. Authors’ calculation assuming that spending and savings both grow 6.7 percent a year, which is the growth rate assumed by CMS actuaries for national health spending over the next decade. See S. Keehan et al., “Health Spending Projections through 2017: The Baby-Boom Generation Is Coming to Medicare,” *Health Affairs* 27, no. 2 (2008): w145–w155 (published online 26 February 2008; 10.1377/hlthaff.27.2.w145).