Blending Better Ingredients For Health Reform

Some features of both presidential candidates’ health reform plans would work better together than separately.

by Mark V. Pauly

ABSTRACT: This paper argues that a desirable health reform plan should accept some features that the Obama and McCain plans have in common, and combine other features from each of the plans. Useful combinations include the presence of both public and private options and a system of credits that are more generous for lower-income households (Obama) and creation of a system of public subsidies that is incentive-neutral across individual and group insurance, curtailment of the current tax subsidy to high levels of coverage for high-income households, and the use of targeted high-risk pools and guaranteed renewability rather than community rating (McCain). [Health Affairs 27, no. 6 (2008): w482–w491 (published online 16 September 2008; 10.1377/hlthaff.27.6.w482)]

During the 2008 presidential campaign, both major-party candidates—Sen. John McCain (R-AZ) and Sen. Barack Obama (D-IL)—have proposed health plans intended to alter the way the federal government deals with health insurance.1 Given rising medical care spending and insurance premiums, and the fact that one in six Americans lacks public or private health insurance, it is no wonder that this has emerged as an issue.2 It is also no wonder that each candidate’s plan tries to cast its scheme as much superior in all aspects to that of his opponent. In this paper I begin with the premise that neither ideal focus nor good implementation are likely to reside in one place. I try to specify some features of both plans that are promising and would work better together than separately. However, I do not take the overly simplified view that you can put together a plan with some aspects from Column A and others from Column B, as if complementarity or mutual incompatibility did not exist—they do. And some ideas in each plan have little merit no matter what. I also do not imagine that everyone will agree that all elements of a compromise will be best from their perspective; there will be a strong temptation to rehash the old arguments in favor of what one likes and proclaim oneself unconvinced about alternatives—to revert to the partisanship that has so far prevented action. And there will still be some trade-offs that

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depend on value judgments. However, I close with the outline of a program that embodies what I regard as an appropriate give and take.

**Elements Common To Both Candidates’ Plans**

- **Inclusions.** Both plans have some desirable features in common. The two main commonalities are the desire to offer a range of insurance options to the currently uninsured and a desire to redistribute the help and incentives government gives for insurance purchasing toward more help and stronger incentives for lower-income people and away from current strong incentives for generous insurance for and transfers to higher-income people. There are some differences within these broad similarities that matter: Senator Obama wants to include a government-sponsored insurer in the mix for individual markets and strongly regulate the markets in which individual and group plans compete. Senator McCain’s plan includes only private plans and would permit individual insurers and insurers from other states to compete with less regulation. Senator Obama’s explicit subsidies are steeply scaled by income. Senator McCain uses a combination of uniform gross subsidies (for example, $5,000 per family) and removal of the insurance tax subsidy that leads to reduced net subsidies to the well-off and larger net subsidies for the less-well-off.

Permitting choice seems to be desirable, given the variety of insurance plans Americans choose; consumers’ revealed preferences are not identical. There will need to be strong protection for neutral subsidies and neutral regulation if there is to be unbiased choice. Still, both markets with choices and means testing have been installed as common characteristics of a reformed health insurance system.

- **Exclusions.** Equally relevant are approaches to health reform that are not present in either plan, despite strong affection for these approaches from some parts of each candidate’s base. Specifically, neither candidate advocates an approach in which the only insurance plan would be a tax-financed, government-run or -contracted plan with minimal cost sharing at all income levels, or in which total spending would be controlled by government. Quite the contrary: both candidates envision a role for private insurance, the use of cost sharing in insurance for the middle class and above, no government spending controls, and a combination of beneficiary-paid premiums with whatever tax-financed subsidies are present.

At the other end of the political spectrum, neither candidate advocates major reliance on a system dominated by high-deductible insurance plans, private accounts earmarked for those deductibles, and a private market where providers selling groups of services to treat an illness (rather than individual services or capitated products) are set up to play the major role. Senator McCain’s plan does endorse unspecified expansion of the (thus far) small fraction of the market with high deductible-savings account plans but does not propose that such plans be the only ones qualifying for tax credits. Instead, both plans have public incentives and regulations that are indeed largely neutral, neither encouraging nor discouraging one insurance type compared to another. Both imagine that the final choice...
will be made by consumers, not by physicians, health management professors, federal bureaucrats, labor unions, or trade associations. But not all parts of the process in each plan are set up to promote neutral, bipartisan action. Some features of both plans are troublesome, in terms of their economic rationales and incentives, and equally because they hinder rather than help political transparency. My discussion is not just about economic pros and cons; I suggest judging some features of these plans by the candidates’ own standards of plain talk and rejection of old politics, and I highlight some major parts of both that are sorely in need of improvement.

**Employment-Based Health Insurance**

The bulk of private health insurance in the United States is supplied in connection with employment; partial employer-paid (and tax-shielded) insurance premiums are part of the compensation package offered to most workers. Both candidates’ plans have to deal with this arrangement, but they do so in different ways. What advantages might be combined and disadvantages avoided?

There is considerable confusion (from an economic perspective) among policymakers, employers, and workers about how employer-sponsored insurance really works. The economic analysis of employment-based benefits is as clear in economic theory and empirical work as it is muddled in the public debate: theory and econometric studies both say that workers pay for the majority of health insurance costs, through lower money wages as well as through explicit premiums.\(^1\)

- **Tax credits versus mandates.** The two plans differ greatly in the extent to which they recognize this view. One of the McCain plan’s central features is a proposal to completely end the provision in federal tax law that allows both the employer-paid part of the premium and explicit employee premiums (in the very common “cafeteria plan” arrangement) to be excluded from workers’ taxable income.\(^2\) Compensation paid in the form of contributions to group premiums would be taxed, and a simple fixed-dollar refundable tax credit ($2,500 for worker-only coverage, $5,000 for family coverage) would be provided to all, regardless of the actual premium for the insurance they chose, and regardless of whether the insurance was employment-related or individual.\(^3\) The McCain approach is thus based on the view that workers pay for and get the tax breaks from their health insurance but that those tax breaks need to be reformed and rearranged.

The Obama plan, in contrast, generally seems to view employer payments as do many employers: as the employer’s money, which would otherwise become part of profits if it were not paid out for health insurance. It proposes a play-or-pay employer mandate.\(^4\) The precise rationale for this scheme has not been detailed, but sentiments about the necessity for all employers to pay their fair share of the cost of insurance for workers—either directly or through the mandated penalty—strongly suggest that it is based on the view that the cost of this mandate will largely fall on owners of capital and not on workers’ wages.
How would the cost of the play-or-pay mandate be distributed? The employer mandate part (“play”) would function generally as a head tax on worker wages, reducing money wages by an equal amount, regardless of wage level. The alternative of paying 6 percent of payroll toward insurance premiums (“pay”) would be more attractive than employer provision of benefits for firms whose cost for a qualified plan would exceed 6 percent of payroll. For these firms, workers’ wages would be reduced as if there were a 6 percent payroll tax.

The main problem with such mandates and taxes is not so much their economic-efficiency consequences or even their effects on equity (although the head-tax character of the option to play might be viewed as efficient though unfair) but their political-transparency consequences: they have a toxic effect on business views on health reform, and they confuse everyone else. They engender strenuous business opposition to reform, even from businesses where the ostensible bitterness has been sweetened with subsidies. In the tragic paradox of health reform (as illustrated most recently in Massachusetts), substantive employer mandates kindle fierce employer opposition, even though, according to economics, employers are not the major stakeholders but are primarily conduits for payment for workers’ health insurance.14

Employer mandates imposed in the current market could have some modest differential effects on firm profits. Small businesses are much less likely than large ones to provide insurance; mandates would then impose a differential cost on high-wage small businesses, for which coverage is usually more costly than average. A mandate may benefit employers already offering coverage (perhaps from union pressure) by restricting their competitors in the labor market.15 So there might still rationally be some objection from some affected employers and support from others, but the strength of the objections would be much less under a correct view of incidence than if employers think it is all their money. Forgoing mandates in favor of credits for workers would provide little gain to employers as a class but would avoid stirring up unnecessary and unenlightened but often effectively obstructive behavior from employers.16

Political considerations. There is more at issue here than just economics and enlightened self-interest: a desirable element in political choice (and one much emphasized by Senator Obama in other settings) is political transparency. Employment-based insurance (whether mandated or voluntary) makes choices opaque if not biased; those who think they are getting a net benefit (such as previously uninsured workers) will be getting much less than they imagine because their raises will fall, while those who think they are being unfairly burdened (such as unsubsidized employers) will be paying much less than they think.

Senator McCain’s plan has different problems with employment-based coverage, and its problems are also political. The most obvious problem is the questionable political attractiveness of a proposal to abolish a popular upper-middle-class tax loophole, one that delivers more than $200 billion a year in avoided taxes, pri-
arily to higher-wage Americans. It might be preferable to begin by capping the exclusion with a cap that does not grow as fast as premiums, and thus gradually withdrawing the subsidy. Whether it is done quickly or slowly, there are efficiency as well as equity advantages to be gained from limiting this loophole. Compared to paying for subsidies by imposing or reinstating higher marginal tax rates for some or all of the middle class, this alternative way of collecting more from well-off households not only improves equity but does so in a way that will make health insurance markets work better.

The proposal to replace the tax exclusion with a fixed-dollar credit contains other controversial features. The credit would be offered uniformly in a predetermined amount to everyone, regardless of the insurance they get. Thus, it would not inappropriately push people into or away from group insurance, or bias choices for or against high-deductible insurance. Rather, it would push choices toward insurance that the consumer judges to be worth its true (unsubsidized) cost. This neutrality is important because group insurance is usually less administratively costly than individual purchase, and sometimes managed care is better than high cost sharing to limit overuse. However, individual insurance can give different individuals the coverage they want, and managed care makes some people angrier than high deductibles. Neutrality allows these trade-offs to be made properly. For example, a policy that delivers the same benefits might be 30 percent more expensive if arranged as an individual policy rather than through a large group. After a $2,500 credit is applied in both cases, the group policy will still be cheaper than the individual policy, and the consumer must decide whether the potentially better fit in the individual market is worth the higher price. Switching from the group to the individual market should generally be limited to small firms with heterogeneous high-wage workforces, where only a large tax subsidy was previously binding the group together.

Risk Segmentation And Help For High Risks

Both plans contain provisions that would help some workers and dependents who are “high risks”—in the sense that their expected expenses under a given insurance policy are above average. The Obama plan would offer subsidies to insurance groups to cover the costs of their high-cost claims, and would require individual insurance premiums to be the same regardless of health status (modified community rating). The McCain plan would provide federal subsidies to state high-risk pools with a Guaranteed Access Plan (GAP).

It is plausible that the community wishes to make transfers to the part of the population who have expected expenses much above average for reasons largely outside of their control, and who do not have high incomes. The two different approaches share the goal of redressing this inequitable and inefficient practice, but they differ in how they propose to accomplish it.

Where not restricted by regulation, individual insurers try to set premiums for
new customers based to some extent on those customers’ expected expenses at
the time of sale; Senator Obama wants regulation to stop that practice. However,
after the initial purchase, almost all individual insurance is “guaranteed renewable”
at class-average rates for subsequent periods. Premiums will not be in-
creased selectively for those who become higher risks; the problem of risk rating
therefore may be much less severe in such cases. Recent data confirm older find-
ings that people in individual markets are largely protected against future reclass-
ification risk.19 In contrast, buyers of group insurance who are or become high
risk and lose their employment for any reason have no protection against the re-
classification risk that will occur if they move to individual insurance.20 Neither
option is superior to the other.

What are the pros and cons of a high-risk pool–guaranteed renewability com-
bination (McCain) versus a community rating–reinsurance subsidy combination
(Obama)? Community rating is equivalent to financing a subsidy to all high risks
with an excise tax on insurance purchased by low risks, regardless of income. Like
other excise taxes, this regulation-produced tax scores poorly on both efficiency
and equity. It inefficiently induces below-average risks to drop insurance or cut
the coverage they buy. The community rating variant will also subsidize high risks
who have high incomes.

My judgment is that community rating is inferior to the combination of guaran-
teed renewability and high-risk pools, assuming the latter could be subsidized
sufficiently, with financing from general revenue taxation, but that the Obama-
proposed coverage of high risks through what is effectively free reinsurance also
has merit. Some combination of all three desirable features might be best.

**Cost Containment**

What about features in both plans for “cost containment,” defined as perma-
nently slowing the growth in real medical care spending per capita? Both contain
surprisingly similar invocations of popular methods said to hold the promise of
improving quality while controlling cost: health information technology (IT)
with interoperability, pay-for-performance, and more emphasis on primary and
preventive care.21 Although there are reasons for hope that plans based on these
ideas might lower costs, there is little evidence for optimism based on proven per-
formance. Cheerleaders for each scheme project cost savings of “as much as” sev-
eral billion dollars, which sounds like a lot of money but is minor compared to the
$150 billion or so in spending the medical care system adds each year.

The main problem is that these are “if only” savings, which can be achieved “if
only” certain events would occur, such as physicians’ being willing to adopt health
IT, consumers’ being willing to accept changes in diet and exercise, the timely re-
ceipt of preventive care, or full trust in primary care doctors who are custodians of
a medical home. In contrast, cost savings from limiting the exclusion only require
the government to take action.
There is little evidence that there are known methods to cause the “if only” behavior to occur, and to occur quickly on a large enough scale to matter. Few of the innovations relate directly to controlling the new technology that is driving spending growth, so they cannot promise the kind of large and permanent reduction in spending growth (not levels) that is needed for true cost containment.

There is evidence that high and growing premiums fueled by tax subsidies to the upper middle class affect the premiums for all private insurance, and thus make it unaffordable for lower-income people.22 There is some evidence that either higher cost sharing or stronger managed care may also reduce the rate of growth in spending over reasonably long periods of time.23 The evidence on this is not conclusive but is at least as good as the evidence for other cost containment devices, and likely to have a much bigger impact to boot.

**Means-Testing And Budgetary Cost**

Both plans promise higher net financial benefits (compared to the present) for low-income households relative to high-income households. The Obama plan collects most of the cost from upper-income households and pays most of the subsidies to lower-income households. The McCain plan, by taxing employment-based benefits, also increases taxes on the well-off much more than on the poor, but it then offers the same credit to all. The details of both plans on income targeting remain to be worked out.

Uniformity of credits has the virtue of simplicity, but there should be room for further adjustment in the direction of higher subsidies to the very poor and lower subsidies to households far from the poverty level. Means-testing the credits reduces the size of the tax increase needed to fund them, and this is a major plus in the Obama plan. Some careful maneuvering is called for here, but tapering both payments for health insurance and the minimum generosity of coverage of health insurance with income (low cost sharing for low-income people but higher cost sharing permitted for the well-off) seems a desirable and inevitable characteristic of any financially feasible plan.

**Toward A Compromise Plan**

What kind of compromise plan might preserve the good features of both the McCain and Obama plans? Although no compromise will be judged convincingly best by dedicated supporters of either side, here I outline the implications of the previous discussion for a plan that might embody some give and take and that would lead to a good outcome.

This plan would obviously include the common points between the two proposals: offering multiple options in individual and small-group insurance, and permitting group insurance (usually with multiple options, although not necessarily so) to be retained when employers and employees prefer it to the alternative of higher money wages and participation in a more costly individual market. The
compromise would make sure to redirect and redesign tax subsidies and tax credits so that higher-income households get less fiscal benefit than at present and lower-income households get more, while providing stronger incentives to lower-income households to obtain coverage and weaker incentives to higher-income households to choose overly generous coverage. The tax exclusion would be capped and then reduced over time.

Tax credits for insurance would vary inversely with income (as in the Obama plan) but would be available to all households that obtain qualified insurance, whether as group or individual insurance (as in the McCain plan). Insurance options in the individual market would include both private and government-run or -contracted plans, with guarantees of neutral treatment of each. Minimum qualifying coverage would have low out-of-pocket payments for lower-income but more generously subsidized households, but would permit better-off households to choose plans with higher deductibles if they prefer.

There are major compromises here. Admitting public plans as options and means-testing the tax credits would be a large change for McCain; paying credits that are the same whether insurance is individual or group would replace the Obama play-or-pay provisions. Such compromises could create major financing gaps in each plan: without recapturing the whole tax subsidy, the McCain plan cannot come close to covering the costs of its tax credits, and removing play-or-pay means that the Obama plan would have to finance tax credits for many more people than if credits were restricted to those using the individual market. General revenue taxes would have to be increased to close either gap, and that may be the hardest part of hard reality when it comes to proposing plans to reduce the number of uninsured Americans. Many people who have insurance and pay taxes will have to pay more taxes; there is no plan that can pay for itself or be covered by taxing only a few. Measurement of income and crediting of subsidies could be administered by employers as part of the process of determining tax withholding, and for workers currently with coverage, employers could administer the change in take-home pay and the change in insurance options.

Individual and, ideally, group coverage as well would contain guaranteed-renewability features so that people who contracted a chronic condition would continue to pay the same premiums as those who did not and so would not need rate limits from community rating or need to use the high-risk pool. If people get insurance when they are healthy and if guaranteed renewability works, the set of people needing additional protection might eventually become tiny.

Choosing the method for direct subsidies to remaining middle- and low-income high risks is a judgment call. The choice is between guaranteed renewability backed up by federally subsidized high-risk pool (McCain) versus modified community rating backed up by federally subsidized reinsurance (Obama). Recent research indicates that there is very little impact on the proportion of high risks obtaining coverage, whether or not risk rating in the individual market is limited.24
Compared to the alternative, limits on risk rating modestly increase that proportion, but at a cost, in terms of the dropping of insurance by a larger number of adversely selecting low risks. Perhaps a compromise would have guaranteed renewability for people renewing coverage, while new buyers from a given insurer (whether coming from group insurance or uninsurance) would face three corridors, depending on how much risk differs from average: a corridor where risk rating would be permitted for people of moderately-above-average risk, a corridor where community rating would forbid further premium increases, and a corridor where much higher risks are referred to a well-subsidized high-risk pool. It will also be important to ensure that regulation intended to limit risk segmentation not be used as a subterfuge to disqualify less generous plans that special interests (provider groups, public health advocates) do not like.

In the short run, such a system with income-targeted neutral tax credits replacing all or a major part of the employment-based exclusion could greatly reduce the number of uninsured people (the amount of reduction depending on the generosity of the subsidy and the specifications of minimum qualifying coverage). In the long run, such systems would put in place strong incentives for people at all income levels to seek insurance and to chose insurance that provides the most value for money, and would permit differences in insured people’s preferred ways of achieving this goal (for example, cost sharing versus managed care versus lifestyle changes). This change could slow the growth in medical spending, but its paramount advantage is that it would ensure that whatever growth occurred was in accord with individual and social values placed on health care and financial protection.

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NOTES
7. Some commentators despair at the thought that government could ever avoid favoring its own public
plan—which implies that the only options are all government or no government. I do not take that pessimistic view.

8. There is a concern that Obama’s pledge of “affordability” will inevitably lead to spending controls. I am interpreting his plan as not implying affordability for the government but rather enough subsidization so that coverage and care are affordable (however that term is defined) for lower-income households.

9. Indeed, if the tax credit is made available for people who would buy any kind of individual insurance, the attractiveness of individually purchased managed care or indemnity plans would be enhanced relative to [spell] (CHP)/medical savings account (MSA) plans, which currently get an exclusive subsidy. On the other hand, it appears that the consumer can qualify for the credit even if buying a low-premium plan with a high deductible or aggressive managed care. Some critics of the plan point out that the credit is less than half of the premium for a typical comprehensive plan, and they incorrectly infer that people may remain uninsured because they will not pay the other half. However, the credit is a very large fraction of if not equal to the premium for less costly plans. So the net result should be almost everyone with coverage, but the coverage being somewhat limited. This is not ideal, but it is better than having people remain totally uninsured, and probably better than having fewer people with more generous coverage. On the trade-offs here, see M. Pauly and B. Herring, “Expanding Coverage via Tax Credits: Trade-Offs and Outcomes,” *Health Affairs* 20, no. 1 (2001): 9–26.


15. If we assume that the higher loading (difference between premiums and expected costs) for small-group insurance raises premiums about 10 percent above average, the additional cost borne by small employers would be about $300 for worker-only coverage—the same order of magnitude as the vestigial penalty in Massachusetts for employers who do not arrange coverage.


17. McCain-Palin, “Straight Talk on Health System Reform.”

18. Social concern is presumably strongest for lower-income people who, in a perfectly risk-rated insurance market, would, over time, be subject to “reclassification risk”: the risk that because of the unexpected onset of a chronic condition, all future premiums will become much above average.


