Corrine Parver: Welcome everyone to the second in a series of debates on the presidential candidates’ health policy platforms. We held this same type of program before the elections in 2004. I am pleased that you all have a chance to come and listen, and participate in what will be a very exciting and energizing hour. I am the Executive Director of the Health Law Project at American University Washington College of Law (WCL). There are representatives here from the WCL Health Law and Justice Initiative, which is the student health law association, as well as editors and staff members from the Health Law & Policy Brief, which is the biannual student publication of health law and policy articles.

It is my great pleasure today to welcome our guest speakers. We have representatives from the supporters of the campaigns of Senators Barack Obama and John McCain, and Richard Teske, who was a Department of Health and Human Services official in the administrations of President Ronald Reagan and George H. W. Bush. After his government service, Mr. Teske held positions advising pharmaceutical and medical device companies and, more recently, he has advised state governments on making their Medicaid State Health Programs more robust.

Gwendolyn Majette is a Global Health Law Scholar at Georgetown University’s Law Center. She has had significant experience working on health law issues, including the analysis and review of Medicare policy as a Fellow with the Health Subcommittee of the House Ways and Means Committee. She currently serves on Senator Obama’s Volunteer Health Policy Committee.

Heide Bajnrauth began her health career working for Senator John McCain on legislative issues in the late 1990s. She is a public policy advisor at Patton Boggs in Washington D.C., which is one of the major law and lobbying firms in the Nation’s capitol. She consults with clients in biotech, pharmaceutical and medical device fields on payment issues, reimbursement processes, and health policy regulations. She is currently advising the McCain-Palin presidential campaign on health care issues.

We are going to begin the discussion with Gwen Majette, who is a supporter of Barack Obama.

Gwendolyn Majette: Good afternoon everyone. It is a pleasure to be with you this afternoon. I am a lawyer so I do have a disclaimer: I am not an official spokesperson for the Obama campaign. My presentation today is based upon my own personal views and should not be attributed to the campaign.

Barack Obama’s plan or strategy to provide health care to all Americans includes three key components that his plan focuses on: affordability, quality, and portability. By this I mean that Obama’s plan is designed to provide affordable, quality health care, as well as affordable, quality health insurance. Health insurance will be portable, meaning that as individuals change their jobs they will have access to affordable, quality health care.

Obama’s proposal is designed to build upon our current system using those things that work well, so those individuals who are currently satisfied with their health insurance plan can continue with those plans. Obama’s plan is also designed to expand coverage to the 46 million uninsured individuals in the United States, and to increase the value of the American health care system.

What does our current system looks like? Our current system of health care insurance coverage is primarily provided by two groups. The first and the largest is employer-sponsored health care. A Kaiser Family Foundation report shows that 54% of the people currently receiving health insurance receive it through their employers. I have seen some numbers today that suggest that two-thirds of the adults that have coverage receive it through their employer.

The other large provider of health insurance coverage is the government. Medicaid and other public programs like SCHIP provide 12% of coverage; another large portion of people are covered through Medicare — 14%. So, if you combine the employer-sponsored
coverage of 54% with the government-sponsored coverage of 26%, you will see that 80% of people are covered through employer-sponsored plans and the government plans.

Now, how specifically will Obama achieve coverage for all? President Obama will sign, in his first term, a universal health care plan that has five core attributes. First, he will create a National Health Plan for individuals and small businesses to obtain affordable, quality coverage. This type of coverage will be comparable to what federal employees are currently receiving. He will also establish a National Health Insurance Exchange, which would allow individuals who choose to purchase private insurance to have a place to go where they can find affordable, quality, comprehensive plans to purchase. It will also moderate and provide fair rules of operation to make sure that insurance companies are treating insured consumers fairly.

The third attribute of Obama’s plan is to preserve employer-sponsored health insurance. As I said before, two-thirds of adults have employer-sponsored coverage, so Obama’s plan preserves that coverage by having an employer mandate. This mandate basically says that employers will be required to make a fair contribution to the health coverage costs of their employees, either by continuing to provide the insurance coverage that they provide or by paying some type of assessment toward their employees’ insurance costs. Today, small employers and very small businesses do not provide coverage at the same level as larger employers. The Obama plan is designed to give them some incentives to provide coverage in the form of a small business tax credit. Small businesses and entrepreneurs who cannot afford it will be exempt from this employer mandate.

The fourth attribute of the Obama plan is to expand Medicaid and SCHIP. Some of you might not know, but during the most recent years as the number of uninsured has been increasing, it has been Medicaid and SCHIP that have been providing more coverage to those individuals. SCHIP specifically covers more children. The fifth aspect of the Obama plan is to leave Medicare intact for seniors and others (primarily individuals with disabilities).

Now, how is the Obama plan going to increase the value of the money that is currently being spent on health care? Well, there are several core components that the Obama plan uses to get more value from the system. According to the economists working with the campaign, individual families should be able to save $2,500 with their health care coverage costs under Obama’s plan.

The Obama plan is going to focus on prevention. This is very important. There will be a shift towards providing more care via primary care providers. Many other industrialized countries in the world use primary care providers as the bulk of the providers of health care; and in those other countries, their health care costs are lower than ours and they also have higher value and better outcomes. This idea of focusing on primary care is not something new. The World Health Organization since 1978 has had a “health for all” agenda and has viewed primary care as a way to make sure that more people have access to affordable health care. When we are thinking about prevention, it is not only primary care, but we are also thinking about public health initiatives, such as focusing on tobacco cessation and the obesity problem.

Obama’s plan will also focus on chronic disease management. Some of you might be aware that the incidence of chronic disease is increasing in the United States. The cost of care for people who have chronic diseases, especially multiple chronic diseases, is very expensive. So the Obama plan is designed to help screen for these diseases early and to help teach people how to better manage their care. Early intervention prevents complications that lead to expensive health care, like hospitalization.

The Obama plan is also going to emphasize Health (IT) as a way to reduce unnecessary and wasteful spending, medical errors, duplicate testing, and inefficient
billing. Health IT will also help identify who the best providers are, what the best treatments are, and what the best patient management tools are. The Obama plan proposes to invest $50 billion in Health IT. Other countries use Health IT more. Because of the high costs of Health IT, some type of financial contribution from the federal government will be needed to facilitate broad adoption of Health IT. Financial assistance is especially important for the many small physician practices that constitute the bulk of our physician practice in the United States.

The Obama plan also will have and encourage increased competition. The National Health Exchange is going to set standards for insurance companies and provide an environment for insurance companies to compete. The Obama plan will also increase competition in the drug markets by doing things like encouraging generic use of drugs.

Additional tools that will be used to add value in the Obama plan include transparency of cost and quality data. Here we are talking about what health care providers are doing, and getting data to make sure that they are providing quality, cost-effective health care services. We can require health care providers to give us data about medical errors; we can require hospitals to give us data about nurse staffing ratios; we can require hospitals to give us data about their hospital infection rates; and we can require them to give us data about health disparities. The data will help us decide who we want to use in our health care system, who are the best providers, and how can we get the most value for what is being spent. We are also going to impose disclosure obligations on insurance companies. We want to make sure that insurance companies are using the bulk of our premium dollars to provide medical care and not on administrative costs and, again, disclosure is the way that we can do that.

A core component of the Obama plan is the idea of comparative effectiveness. An institution will be established with the purpose of determining what medical treatments do not work. The medical literature shows that we do not currently know the effectiveness of many of the medical treatments that are provided today.

Another core reason why comparative effectiveness is important is because the chief driver of costs in the U.S. health care system, according to many reports, is the use of and adoption of new technology. We need to make sure that that new technology is cost-effective before it is adopted. This is something that we see in other countries. For example, England has an organization called the National Institute for Clinical Excellence (NICE), whose job is to advise the government about which health care treatments are cost-effective.

Another core component of the Obama plan is performance-based payment for physicians. You might have heard the term “pay for performance.” The Obama plan will use this payment methodology. According to a large insurance carrier, using pay for performance and redesigning how it pays physicians is going to be the primary method to control costs. Physicians will no longer be paid based upon volume — the more volume, services, and procedures they provide the higher the pay. Instead, we are going to provide incentives to physicians to focus on the types and quality of care that will improve the health outcome of their patients so that we pay for better health outcomes.

The final feature that I want to emphasize is that the Obama plan will have a federal reinsurance plan. Essentially, what this will do is enable employers to continue offering affordable health care coverage when they have an individual employee in the group who has high health care costs. Under our present system, insurance companies typically raise the premiums for such employers; this results in everyone’s premiums going up. Consequently, the employer may eventually be forced to drop the coverage or all of the healthy people leave the pool. The Obama plan will offer a federal reinsurance pool to help the employer cover those costs. Access to federal reinsurance is permitted as long as the employer promises that the savings will be used to lower the costs for their employees and continues to provide coverage. Those are some of the core features that I wanted to talk about with respect to the Obama plan.

In contrast, I want to talk about some of the features of the McCain health care reform plan. The design of the McCain plan will erode the employer-based health insurance that we talked about, which effectively pools group risk. It is going to do this by taking away the benefit that many employees receive by not being taxed on the contributions that their employers provide to employees for their health insurance coverage. Now, economists talk about this and they say that employees really do not benefit from the receipt of employer-provided health insurance because their wages are reduced by the amount of money that their employers pay for the insurance. What we do not know is that if we take away the benefit that encourages employers to buy it, whether they will use the savings to continue to provide coverage. Under the McCain plan, there is nothing to ensure that this occurs, but under the Obama plan there is an employer mandate. By unraveling group-provided health care that occurs through
Because people no longer have the tax exclusion for the value of their plans, related financial difficulties are likely to be exacerbated under the McCain problems paying for health care and health insurance. These health care facing because of the recent downturn in the U.S. economy. An August their coverage. So, probably underinsured or suffered from insurance companies dropping

In 2001, half of the people who filed for bankruptcy cited medical causes as they had difficulty paying other bills; they were unable to pay basic necessities; they borrowed money; and they declared bankruptcy.

The levels of those premiums are exorbitant. Currently, less healthy individuals have difficulty obtaining coverage. McCain’s solution to providing care to high-cost individuals is to build upon a model using high-risk pools. The problem with the high-risk pools is that the premiums are two times the premiums of the healthy individuals and the pools are financially unsustainable. For example, Maryland started a plan and within five years, that plan essentially went bankrupt because the high costs led to large payouts. So use of high-risk pools can be troubling.

I want to continue to talk about the financial consequences of either being uninsured or being underinsured. A poll conducted by the Kaiser Foundation showed that these individuals experienced adverse financial consequences as a result of medical bills. People were contacted by collection agencies; they had difficulty paying other bills; they were unable to pay basic necessities; they borrowed money; and they declared bankruptcy.

In 2001, half of the people who filed for bankruptcy cited medical causes as the reason for filing. These people were not primarily uninsured; they were probably underinsured or suffered from insurance companies dropping their coverage. So, 76% of the people had insurance at the onset of illness, yet one-third who were privately insured lost their coverage.

A more recent Kaiser survey analyzes the problems that people are currently facing because of the recent downturn in the U.S. economy. An August 2008 survey shows that 24% of the people surveyed said that they had problems paying for health care and health insurance. These health care related financial difficulties are likely to be exacerbated under the McCain plan.

Additionally, McCain’s plan would increase taxes on some individuals. Because people no longer have the tax exclusion for the value of their employer-provided health insurance, one survey from the Kaiser Foundation and the Center for American Progress showed that couples making $60,000 in Maryland and Virginia would not only have to pay that $7,000 shortfall that was discussed earlier, but would also have to pay a tax — in Maryland and Virginia $1,500; and in D.C., $3,100.

Under the McCain plan there are weaker regulatory protections for consumers. The plan provides for an unregulated insurance market or a less regulated insurance market. Some of the protections that people currently have would be eliminated. In states that mandate certain benefits, such as cervical cancer screening or colorectal screening, insurance companies will no longer be required to offer them. If women are diagnosed with breast cancer, the insurance plans do not have to cover breast reconstruction surgery. So the mandates will be eliminated or plans will go to the states that have the least amount of regulation — either way it is not good for the consumer.

Other consumer protections came into existence because of problems that we had with managed care. Managed care has both positive and negative attributes. Under the McCain plan, some of the procedural protections from managed care’s negative attributes may no longer be in place or they will be avoided — things like expedited review. Basically, if an insurance company decides that it is not going to pay for care that your physician has said that you need, you would no longer have the right to have that decision evaluated.

In summary, I think that the Obama plan is the better health plan for Americans. It provides access to affordable health care as well as affordable health insurance. Insurance coverage is portable because features like the National Health Insurance Exchange, as well as the national plan for small groups and individuals, facilitate the provision of coverage to individuals who no longer have access to group coverage. Obama’s plan lays the groundwork for a high-performance health care system.

Heide Bajnrauh: I had the pleasure of working for Senator McCain on Capitol Hill for a few years. I worked for him in his state office, as well as in D.C., so he gave me an incredible opportunity. He actually was the one who pushed me into health care. I would like to thank the American University Washington College of Law for putting on this informative program. I think it is really important to hear different aspects of the health care reform plans so that you can make your own informed decision.

Senator McCain sees many of the problems with the U.S. health care sector as rooted in the encroachment of regulation and bureaucracy. I am sure everyone here has been to the DMV or any other place where you have to stand in a really long line and wait to get any sort of benefit that you think that you should have gotten first-hand without having to go through the whole slow process. I, as a D.C. resident, have encountered that quite often.

McCain wants to unleash incentives to create more competition in the private health care sector that would give people more choices and more affordable care and coverage. The senator has pointed out numerous times, and I quote, “The real key to reform is to restore control over our health care system to the patients themselves.” John McCain’s vision for America’s health is based on four pillars of reform: affordability, portability and security, access and choice and, finally, quality.

I’ll begin with affordability. John McCain believes in making health care more affordable for all Americans by ensuring that drug companies, doctors,
insurance companies, hospitals, and every other aspect of the health care system competes vigorously to respond to their needs. By rewarding quality, promoting prevention, and delivering health care more effectively and efficiently, we can ensure that every American can afford the health care coverage of their choice. Rising costs represent the greatest threat to achieving all of these goals. As we all know, and hear in the news every day, it is really the cost that is the issue. It makes it difficult for families and businesses to afford private coverage and puts increasing pressure on taxpayer dollars, which are paying the bill for these public programs like Medicare, Medicaid, and SCHIP. Cost puts health insurance out of reach for tens of millions of uninsured Americans.

Senator McCain would begin by creating a new and fairer tax subsidy that gives everyone equal help in purchasing coverage and that would unleash the power of the competitive marketplace to bring down costs. He proposes a tax credit of $2,500 for individuals and $5,000 for families to obtain basic health insurance. The credit would be refundable, meaning that people would get the full amount even if their tax bill is less than that. People who have job-based insurance today would see little change and could keep their current coverage. Nothing would change with the employer. They could still offer you the same health benefits that you receive today, but the credit would provide help to people shut out of the job-based insurance system. They could choose an insurer or other health care arrangement. Let us say a few years from now you decide that you would like to take some time off, either to help raise your children or to start your own business. You would be able to receive that tax credit to purchase health insurance — keeping yourself insured and your family insured.

This leads to the portability and security pillar. The tax break would be available whether people get their health insurance at work, as a great majority of people do, or whether they purchase coverage on their own or through new groups. This means that health insurance could be portable from job to job. People would have the security of coverage that they can own and keep with them over time, leading to better coordinated care. How often have you changed doctors yourself and had to go over your whole entire medical history all over again? This would actually alleviate that problem. You would be able to continue seeing the same doctor that perhaps you have seen for the last ten years, or maybe see somebody new and get your medical records over there so that care is coordinated — again, eliminating excessive testing and keeping costs down. You would not have to change from one doctor or one network to another when your employer changes insurance companies or when you change jobs, leading to better continuity of coverage and care.

What about those who have high health care costs? Senator McCain would create a new non-profit, Guaranteed Access Plan (GAP) to help those who have trouble getting insurance, usually because of preexisting conditions. He would provide new funding and guidance for the states to create GAP plans that allow people who are currently denied coverage to buy policies at affordable prices. This would not be another unfunded mandate to the states or a new federal entitlement program, but rather a partnership between the federal government, the states, insurance payors, and the medical community. There would be reasonable limits on premiums and additional assistance would be available to help people with lower incomes.

Senator McCain also wants to make premiums more affordable for tens of millions of others and he believes that the key lies in greater competition. As a result of that belief, he would allow people to purchase health insurance across state lines. Opening the health insurance market to nationwide competition would give people many more choices of policies that are not burdened by expensive state regulations that drive out competition and drive up prices. People could choose the best plan for them and their families, and through their choices would put pressure on companies to wring out excessive executive compensation and overhead costs.

For example, I am sure now many of you receive your insurance either through your employer or through the university, or perhaps some of you are still on your parents’ insurance. McCain’s plan would allow you the opportunity to go across state lines to see if there is a better plan for you. For example, if you got a job at a firm in California, that insurance policy would go with you so you would not have to change insurance.

The fourth pillar of quality, which is similar to Senator Obama’s plan, really focuses on the coordinated care that I spoke about earlier, but also focuses on transparency, Health IT, and comparative effectiveness reform. But we have to improve quality of care. So this means providing new incentives for the medical profession to provide better care at lower costs. The biggest public programs, Medicare and Medicaid, can lead the way by paying for outcomes, not just for doing procedures and tests. Transparency is crucial so people can know the
outcome records of doctors and hospitals and what type of tests can be done and what those tests cost.

How many here can tell me what their doctor charges an hour for an evaluation and management visit? Some general practitioners charge $150 an hour, some $220 an hour, and some $95 an hour, depending on what community you live in. Without that knowledge you have no idea what the actual cost of treatment is. Perhaps there is a different doctor that you would like to see that would actually save you money in the long-run.

McCain also believes that it is essential to bring the health sector into the information age and supports providing incentives for doctors to provide better coordinated care through secure health records that not only protect patient privacy, but also make sure that doctors have access to their patients’ medical histories so that they can provide the best care.

He also believes that individual responsibility in health care is crucial — giving people better incentives to take care of their own health. Rather than paying for procedures as we do today, he says we need to institute a new generation of chronic disease prevention, early intervention, and new treatment models to help patients stay healthy. No amount of money we spend on health care in the future will be enough if we do not get control of the epidemics of obesity, heart disease, diabetes, cancer, and other chronic conditions.

McCain also believes that health costs can be reduced by minimizing needless costs from lawsuits and the threat of lawsuits. He would protect doctors from lawsuits if they follow clinical guidelines and adhere to patient safety protocols.

Some criticism has been leveled against Senator McCain for the boldness of his tax credit idea, with some saying that it would spell the end of the employment-based health insurance system that provides health coverage to nearly 160 million Americans. The plan would be little more than an accounting change for the great majority of people with job-based coverage, moving the current invisible tax exclusion for job-based insurance to a more visible and more portable tax credit.

You heard Gwendolyn say that the average costs for insurance for families is something like $12,000. So where do you get the additional $7,000 after tax credit to pay for your premiums? The answer is the same place you do now. If you already have employer insurance, nothing changes — they can still provide the same wages and insurance. The tax credit is equivalent to the existing tax break on a $15,000 policy. If the policy is cheaper, then the worker comes out ahead. If the worker was buying his or her own insurance, then the premium was coming out of his or her pocket anyway; it still will, but the tax credit will offset some of the cost and make it more affordable. If the worker ends up dropping out of employer insurance and choosing one of the many options that will be available, they will have additional cash equal to the premiums they were paying, typically 25% of the total cost, and you will have cut the employer’s cost so he or she will be able to raise your wages. Importantly, the tax credit does not exist in isolation. Competition between insurance companies will allow you to buy better, more affordable, and more customized insurance, which will reduce health care costs for everyone and make insurance cheaper to purchase.

The foundation of Senator McCain’s health plan is the belief in the ability of Americans to make the best decisions about their health care and coverage they and their families need, with new subsidies and market reforms to help make that care and coverage more affordable, more accessible, and higher quality. Senator McCain does not want to force anyone to have health insurance or pay for health insurance. Of the 47 million people that are uninsured today, many of them choose to be uninsured.

Senator McCain says that the future quality of health care in the United States and around the world depends upon continued innovation, which is another one of his pillars. The goal, after all, is to make the best care available to everyone. The McCain health plan focuses on working with businesses and insurance companies to widely employ common sense approaches, like smoking cessation programs, promoting healthier eating habits, and encouraging a more active lifestyle. These do not only reduce incidents of cancer, but also of chronic diseases like diabetes and hypertension. By the way, the tobacco tax was the billing mechanism for the children’s health insurance bill that Senator McCain did not vote for, but Senator Obama did. I just want to raise this point because that is often brought up — why Senator McCain did not vote for the extension of SCHIP — it is because he did not feel it should be funded by encouraging people to smoke more.

Most importantly, John McCain believes that no American, simply because of a preexisting condition like cancer, should be denied access to quality and affordable coverage. This is a very important priority in his health care plan — to make sure that people get the high quality coverage they need. The GAP plan will come into play to actually bring together industry and state, creating higher-risk pools so that people with preexisting conditions can have the insurance that they deserve.

Something that was mentioned to me prior to this talk was how these candidates’ health care reforms will change health care in the future. As I mentioned before, health care is not on a good path — the costs are just unsustainable. Medicare and Medicaid cannot go on. Who knows — it may not even be there when you are 65. At this time we really need to come up with other ways.

One thing that Senator Obama has brought up in the past is the federal employee health insurance benefit plan, which is offered to members of congress, senators, and government workers. Well, I happened to have been on that plan when I worked for the Senate. That plan is also a private market plan and each year insurance companies contract out and vie for that opportunity to cover those government workers. Even in a plan that you think is an all-inclusive insurance market and everyone is going to have insurance, there is still going to be a need for some sort of contracting out. Everyone knows that when you contract out and you send out your proposal, you lower costs as a result of competition.

One of the issues that I think needs to change overall is included in McCain’s plan, as well in Obama’s plan. This is lowering drug prices. Senator McCain is in favor of a safe re-importation of drugs and making sure that generic drugs get to the market faster because brand name medicine is very expensive.

Also, chronic conditions account for about three-quarters of the annual health care bill. So through prevention and early intervention, healthy habits, screenings — those types of things — we can lower costs using health information technologies. McCain would like to focus on promoting and coordinating care, expanding access to health care, Medicaid and Medicare
Richard Teske: Good afternoon.
My role today is to comment on the two presentations you have just heard. I will try to be as fair and balanced in the jargon of today as I can be. In terms of jargon, you have just been subjected to a blizzard: insurance jargon, health care jargon, government jargon. Anybody who gets immersed in health care public policy will tell you that it will take you years to figure out what the jargon means. Once you figure out what the jargon means, putting it together into a cohesive whole is really difficult because only then can you start making policies. A lot of the policies in health care, once made, have a lot of very bad, but unintended, consequences. That is what we are talking about in health care. We are talking about one-sixth of the country's economy. If you make a mistake on your health care policy, you could actually destroy your entire economy.

The three papers that you have in front of you are excellent. The two papers critiquing each health plan are very good.1 The Mark Pauly paper is also extremely good.2 His paper is trying to take the best elements of both plans and come out with a solution. In the last page of Mark Pauly's paper, he says, "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."3 Fine. But the parenthetical is what I want you to look at: "the amount of reduction depending on the generosity of the subsidy and the specifications of minimum qualifying coverage."4 Those are the two issues that we are really talking about here. We are talking about the generosity of a subsidy and the structure of the minimum qualifying benefit package. Those are the two elements that you have to concentrate on.

The major problem in reaching the goal of universal coverage or covering the uninsured and the uninsurable is: Where do you get the money? There are really only four places you can get the money. There is Medicaid at about 12%; Medicare, at 14%; private insurance, which is split between employees and employers, which is just over half at about 54%; and individual plans, at about 5%. The fourth area is out-of-pocket — you just pay for it when you need it. A lot of the uninsured and uninsurable are in that out-of-pocket category. When I talk in front of groups like this somebody always stands up and says, "You know you people in Washington, you just do not get it . . . the solution to health care is very simple" and they give me an X, Y, Z solution. Usually it is a pretty good solution. The problem in Washington is not that we do not have solutions. The problem is that we are awash in good solutions. But the difficulty lies in the fact that you are taking this system from here and going to there — it is the transition period. How do you get from here to there, without incredibly increasing your costs or making structural problems?

My wife tells me that my chief talent in life is blazing flashes of the obvious. Using that, let me just try and put these two Senators' plans into context. There are three things that all insurance policies and programs have in common. The first is eligibility: Who is eligible? Second is the benefits package: What do you get? And third, the cost. Obviously, they are all related, but those are the three, very simply. There are basically two philosophies in providing health care. One is a government-run system; the second is primarily a consumer- or market-driven system. The first one, the government-run system, is a defined-benefits program, like Medicare and Medicaid. What does that mean? It means that you have your eligibility fixed. You know exactly who is eligible for the plan. Your benefit package is fixed. These are the benefits you will get and the cost is variable. Why is that? Because the way it works when there is a defined-benefits program is that, if you are eligible for the program, you are entitled to all the benefits regardless of cost. That is why it is called an entitlement program. This essentially is the Obama plan. He is working off a defined-benefits structure because he's saying, "this is the program I want."

The McCain program is the opposite: it is a defined-contribution program. What does that mean? Again, eligibility is fixed. You are the people we are going to cover. Costs are fixed. McCain will give a set dollar amount to you — no more, no less. You do with it as you please, so the cost is fixed. The variable is the benefits package. That is where the competition comes in. Different employers, like under the federal employee health benefits program, will offer different benefits packages, and you choose the benefit package that you like. It is the benefit package that varies.

In government, you regulate the variable. Look at Medicare and Medicaid: defined-benefits programs,
In the last forty years, 90% of the regulations have been based on cost containment and relatively few have been based on quality or access. Under the McCain program, the cost is pretty much controlled because it is a set amount, but the benefits are where you get the regulation. You look at quality and information; things like that would impact your decision as a consumer.

This pithy example also isolates the problem with both plans. For the Obama plan to work, you need a good benefits package to attract the people to use it. He is not using an independent or an individual mandate. He is not forcing you to buy it. If he forced you to buy his plan, then he could have a low benefit package because everybody would at least have that. But the benefit package has to be rich enough to attract participation in the plan. If you have a really rich benefit package, then what happens? Obama’s plan relies on preserving the employer system. Employers would either have to pay or play. The richer the benefit package the more employers will opt out of the plan — pay rather than play. Think of all the paperwork, all the negotiation, all the headaches that come with playing rather than paying. So you have that tension in the Obama plan.

As part of my eclectic career, for a couple of years I advised the Business Roundtable’s health policy. There was not a single corporation on that committee that would not drop health care coverage tomorrow if they could. Why? Ask GM, Ford, and Chrysler. Pension and health benefits programs are the single most non-competitive element of their cost structure vis-à-vis Toyota and everybody else. This is another problem with the Obama plan.

The problem with the McCain plan is costs. You are getting a set amount, but that amount is not indexed for your income; nor is it indexed for health care inflation. If it is indexed, that is the first thing that is going to be on the table in front of Congress, namely: indexing the amount that your refundable tax credit would be under the McCain plan. Well, if you index it to health care inflation, which usually runs two-to-three times general inflation, again you have costs going out of control. Now, what does this do?

When I joined the Reagan Administration in 1981, I was the de facto head of the Medicaid program and I, like most young political appointees, had two qualifications for the spot. One was arrogance and the other was stupidity. Armed with those two qualities, I knew all the answers to the health care solutions. I was working with a group of officials and I said, “You know the problem with these bureaucrats is they cannot think out of the box. Where is the creativity? They only see this limited way.” Well after a couple of years, I started to learn about the programs and I realized that I was wrong. The problem was not thinking outside of the box: the problem was the box. It is the structure of the programs themselves — not the benefits, not how many tax credits you get, and not how many IT elements you have for “hot gizmos” in the system. The structure of the program itself is the problem. If there is one criticism I would make of both plans, it is that they do not make any structural change.

The Obama plan is resting on employer-based insurance and that is going away. Employers are fleeing that: they do not want to provide insurance. You will find the traditional pension and health benefits in ten years only in one place, for public employees. Otherwise, it is going to be all gone.

The McCain system also does not do anything about containing the costs of the entire program. There are a couple of bells and whistles in there but essentially the costs will run away because of the structure. It is built into the structure of how we provide health care.

The Pauly paper comes close to analyzing these deficiencies. If we are talking about structural change, what would it look like? Remember what I said when I began: Washington is awash in good ideas. It is how you get to your idea that counts. But let’s say that I wave a magic wand and eliminate that problem. What we have now is a health insurance system that covers middle dollar coverage. What do I mean? It means that you have a deductible up to a certain point, then the insurance kicks in, and then if you use a lot of that insurance, your lifetime limits kick off and you are exposed again. So it is that middle band that insurance covers. That is stupid. That is not the way insurance should work. Catastrophic insurance should cover both acute- and long-term care with no lifetime limits. In other words, if you have catastrophic diseases, costing millions of dollars a year, it never knocks out. To afford that, you pay like McCain does — through refundable tax credits. Everybody would get catastrophic, long-term, and acute care coverage. Of course, if you are going to do that, you are going to have a high deductible right there. For the rich, a $10,000 deductible is fine as long they get this to cover their assets, so to speak. But what about the poor? What about the people who cannot cover a $10,000 or $15,000 deductible? That is what you call Medicaid and you do it based on income. Now that is as simple as I can put the ultimate system. This is a huge structural change.

There is one other thing about the McCain program that you have to note. Only five percent of the insurance today is provided to individuals. That means that we really do not know how that market works. I can tell you this, when I met with the health insurance industry and pitched the tax credit program based on individual policies, I debated somebody who wanted national health insurance. I said this can be a piece of cake. I am going to win this one easy. I lost. Why was that? Because the health insurance company marketing departments do not want to sell individual policies. It is a lot easier to go into Ford Motor Company with one guy and sell 500,000 policies in a day rather than sell them one at a time. The cost to the system under individual policies with tax credits is not to be underestimated. We really do not have a good picture of what it would be like given the present market penetration with these policies. That is a quick rundown simplistically of the two plans and their approaches.

In summary, both plans have a lot of good elements. Again, look at the Pauly paper, because he tries to combine them. The two other papers are excellent critiques of the plan but they are not about structural change. I do not think either plan will get us out of the hole of increasing health care costs in the long term. Thank you.

3 Id. at 490.
4 Id.