Executive Summary
Backgrounder
Published by The Heritage Foundation

No. 2198
October 15, 2008

The McCain Health Care Plan: More Power to Families

Robert E. Moffit, Ph.D., and Nina Owcharenko

Senator John McCain (R–AZ), the Republican presidential nominee, has proposed an ambitious health care reform agenda. His plan focuses on four key objectives: making health insurance innovative, portable, and affordable; ensuring care for high-risk patients; lowering health care costs; and confronting long-term care challenges. These goals are meaningful, and McCain's policy measures would advance greater personal choice and control in the health care system.

The McCain health plan tackles the fundamental problem in the current system: the tax treatment of health insurance. Equalizing the tax treatment and financing of health care is the first step to realigning the incentives in the system to provide consumers with better quality care at lower cost. His plan also works to expand coverage options for Americans by promoting competition in the insurance market and partnering with states to develop solutions for those who are hard to insure.

Finally, the McCain plan focuses on improving value and lowering costs through delivery reforms. However, crucial details are missing. Such delivery reforms could prove counterproductive if they are implemented in ways that undermine personal choice or lead to more government control of personal health care decisions.

Key Reforms. The McCain health plan proposes three fundamental reforms that would change the financing of health care and reform the health insurance market to give families more control of personal health care decisions:

- **Equal tax treatment for health coverage.** The Senator would replace the special tax breaks for employer-based health insurance with a universal system of health care tax credits for the purchase of health insurance. These health care tax credits of $5,000 for a family and $2,500 for an individual would be indexed annually for inflation and would be available to Americans regardless of income, employment, or tax liability. Even prominent critics concede that such a tax change is a principled and far-reaching proposal. This change alone would lay the groundwork for unprecedented consumer choice and competition in the health care sector.
- **Health insurance competition on a national scale.** Currently, only federal workers and retirees in the Federal Employees Health Benefits Program benefit from competition among private health insurance companies on a national scale. In sharp contrast with almost every other sector of the economy, competition across state lines in health insurance is virtually nonexistent.

This paper, in its entirety, can be found at:
www.heritage.org/Research/HealthCare/bg2198.cfm

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Washington, DC 20002–4999
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The McCain health plan would change this by allowing individuals and families to buy health plans domiciled and regulated in other states. This would both expand personal options for affordable coverage and force health insurance companies to compete directly for consumers' dollars on an unprecedented scale.

- **Federal assistance to the states to cover vulnerable populations.** The Senator envisions a large role for state innovation and experimentation in health care financing and delivery, but he would provide safety-net funding to ensure coverage of the most vulnerable populations: the hard-to-insure and the uninsurable. McCain's Guaranteed Access Plan would provide federal assistance to the states to secure access to health insurance coverage through state high-risk pools or similar arrangements. His plan would also encourage expanding coverage options for Medicaid enrollees and veterans.

Beyond these major reforms of health care financing and insurance, Senator McCain would also promote specific initiatives to increase the value and reduce the cost of services that individuals and families receive for their health care dollars. These initiatives include promoting the use of health information technology, care coordination and disease management for chronic diseases, transparency of price and quality information, broad application of payment reforms for doctors and hospitals in government health programs, greater use of generic drugs, and use of alternative and less expensive medical facilities for routine care, such as walk-in clinics. He also supports enacting medical liability reform to reduce frivolous lawsuits and defensive medicine in the medical profession.

However, it is unclear exactly how these delivery reforms would be implemented and where he would draw the line between federal action and private initiative. This is a legitimate concern. These policies need to be clarified to ensure that they do not expand the role of government or discourage innovation in the private sector. Focusing on the primary goals of financing and insurance reform would go a long way toward improving value without additional government intervention.

Conclusion. Senator McCain's vision for health care reform is underscored by a principled commitment to personal freedom. He focuses on reforming the system to empower individuals and families to make health care decisions and to control their health care dollars.

At the cornerstone of his plan is reforming the tax treatment of health insurance, long a fundamental obstacle to promoting a more consumer-based health care system. The McCain plan would replace the current tax exclusion for employer-based coverage with a fairer, universal refundable tax credit that would enable Americans to purchase health care coverage of their choosing. The health care tax reform is coupled with a proposal enabling individuals to purchase health insurance from any state in the Union, dramatically expanding coverage options, and opening up interstate competition in health insurance. Finally, the McCain plan would establish a partnership with states to help address the insurance needs of hard-to-insure individuals.

The McCain plan also proposes a variety of delivery reforms, albeit with few details. It is critical that these reform efforts not lead to greater government interference in or control of the care and services available to Americans. Such efforts could compromise the doctor–patient relationship and undermine personal choice.

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The McCain health plan tackles the fundamental problem in the current system: the tax treatment of health insurance. Equalizing the tax treatment and financing of health care is the first step in realigning the incentives in the system to provide consumers with better quality care at lower cost. His plan also works to expand coverage options for Americans by promoting competition in the insurance market and partnering with states to develop solutions for those who are hard to insure.

Finally, the McCain plan focuses on improving value and lowering costs through delivery reforms. However, these delivery reforms could prove counterproductive if they are implemented in ways that undermine personal choice or lead to more government control of personal health care decisions.

Key Reforms in the McCain Plan

The McCain health plan proposes three fundamental reforms that would change the financing of health care and reform the health insurance market

Talking Points

- Senator John McCain's health plan would address the fundamental problem in the health insurance system and significantly increase personal choice and control of health care decisions. According to the Lewin Group, over 26 million Americans would gain private health insurance, and the average family's health care spending would decrease by $1,411.
- The McCain plan would offer Americans generous tax relief to buy coverage that they can keep, regardless of job or job status, by fixing the inequitable tax treatment of health insurance. This is, in effect, a broad middle-class tax cut.
- The McCain plan would create a national market for health insurance by promoting competition and partnering with the states to develop solutions for vulnerable populations.
- McCain's delivery reforms, depending on their implementation, could lead to greater government interference in health care decisions. This would be inconsistent with the Senator's goal of increasing personal freedom.

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to give families more control of personal health care decisions:

- **Equal tax treatment for health coverage.** The Senator would replace the special tax breaks for employer-based health insurance with a universal system of health care tax credits for the purchase of health insurance. These health care tax credits of $5,000 for a family and $2,500 for an individual would be indexed annually for inflation and would be available to Americans regardless of income, employment, or tax liability. Even prominent critics concede that such a tax change is a principled and far-reaching proposal.[2] This change alone would lay the groundwork for unprecedented consumer choice and competition in the health care sector.
- **Health insurance competition on a national scale.** Currently, only federal workers and retirees in the Federal Employees Health Benefits Program (FEHBP) benefit from competition among private health insurance companies on a national scale. In sharp contrast with almost every other sector of the economy, competition across state lines in health insurance is virtually nonexistent. The McCain health plan would change this by allowing individuals and families to buy health plans domiciled and regulated in other states. This would both expand personal options for affordable coverage and force health insurance companies to compete directly for consumers' dollars on an unprecedented scale.
- **Federal assistance to the states to cover vulnerable populations.** The Senator envisions a large role for state innovation and experimentation in health care financing and delivery, but he would provide safety-net funding to ensure coverage of the most vulnerable populations: the hard-to-insure and the uninsurable. McCain's Guaranteed Access Plan would provide federal assistance to the states to secure access to health insurance coverage through state high-risk pools or similar arrangements. His plan would also encourage expanding coverage options for Medicaid enrollees and veterans.

Beyond these major reforms of health care financing and insurance, Senator McCain would also promote specific initiatives to increase the value and reduce the cost of services that individuals and families receive for their health care dollars. These initiatives include promoting the use of health information technology (IT), care coordination and disease management for chronic diseases, transparency of price and quality information, broad application of payment reforms for doctors and hospitals in government health programs, greater use of generic drugs, and use of alternative and less expensive medical facilities for routine care, such as walk-in clinics. He also supports enacting medical liability reform to reduce frivolous lawsuits and defensive medicine in the medical profession.

However, it is unclear exactly how these delivery reforms would be implemented and where he would draw the line between federal action and private initiative. This is a legitimate concern. These policies need to be clarified to ensure that they do not expand the role of government or discourage innovation in the private sector. Focusing on the primary goals of financing and insurance reform would go a long way toward improving value without additional government intervention.

Creating a Universal Tax Credit for Health Insurance

> *I propose to spread the tax subsidy for health insurance more equitably. I would change it to a refundable credit amounting to $5000 for all families and $2500 for individuals purchasing health insurance—regardless of the source of that coverage, regardless of how one purchases*

1. McCain–Palin 2008, "Straight Talk on Health System Reform," at *http://www.johnmccain.com/Informing/Issues/19ba2f1c-c03f-4ac2-8cd5-5cf2edb527cf.htm* (October 8 2008). See also John McCain, "Better Care at Lower Cost for Every American," *Contingencies*, September/October 2008, p. 29.
2. "The McCain health care plan represents a philosophical advance over many other health care proposals, principally in its commitment to redistributing the current tax exemption for employer-based health insurance." Linda J. Blumberg and John Holahan, "An Analysis of the McCain Health Care Proposal," Urban Institute, Health Policy Center, 2008, p. 1, at *http://www.urban.org/UploadedPDF/411755_mccain_health_proposal.pdf* (October 8, 2008).

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it, and regardless of one's income. The tax credit would ensure that everyone has access to the same level of financial support through the tax code to obtain basic health insurance.[3]

Under the McCain proposal, every family would receive a $5,000 tax credit and every individual would receive $2,500 tax credit to offset the costs of health insurance. This would largely replace the current tax break for health insurance that is obtainable only through employer-based coverage. It would *not* change the employer's ability to deduct health insurance as a cost of business. Any remaining balance of the credit could be deposited into an "expanded" health savings account (HSA).[4]

Roughly 80 percent of uninsured Americans are in working families. To maximize the take-up of coverage under the McCain plan, the refundable health care tax credit could be accompanied by a system of automatic enrollment in health insurance, either at the workplace or through a statewide health insurance exchange. States could also be allowed to establish such a mechanism, provided an individual is allowed reject, in writing, both enrollment in health insurance coverage and the health care tax credit.[5]

Senator McCain is the first presidential nominee of either major party to prescribe a universal health care tax credit that would provide access to private health insurance for American families. His proposal builds on the broad intellectual consensus among liberal and conservative economists and health policy analysts, who have long argued that the federal tax treatment of health insurance for employer-based coverage is both inefficient and unfair.

Tax Exclusion vs. Refundable Tax Credit. Not surprisingly, the existing federal tax treatment of health insurance and proposals to reform it are sources of much popular misunderstanding—confusing employer and employee tax breaks—even among journalists who follow health policy.

The existing tax *exclusion* is a special tax break for workers with employer-based health insurance. This means that the value of the health care benefits received through employment is excluded from taxation when calculating an individual's liability for federal income taxes and federal payroll taxes.[6]

The tax exclusion for employment-based health insurance is unlimited, in sharp contrast to other forms of compensation, such as retirement benefits, tuition reimbursements, and child care. This means that the larger the employer's health benefit package, the more tax-free income employees receive. It also favors higher-income workers over lower-income workers. Those who earn more than $100,000 receive a tax benefit between $4,000 and $5,000, while those who earn below $50,000 receive between $600 and $3,000 in tax benefits.[7] Moreover, individuals without employer-based health insurance receive no comparable tax break and must use after-tax dollars to buy health insurance.

Replacing the exclusion with a universal tax credit would be more equitable, both for those at lower income levels and for those without employer-based coverage, and would make federal financing of health care more transparent.

Expanding HSAs. Senator McCain would expand health savings accounts, but his proposal is unclear as to the exact changes that he is recommending. One sensible option would be to end the current requirement that the HSA be linked to a government-specified high-deductible insurance plan—a change recommended by several health policy analysts.[8]

Today, only individuals who have a federally qualified high-deductible health plan can benefit from the tax-preferred savings of an HSA. Individu-

3. McCain, "Better Care at Lower Cost for Every American," p. 30.
4. McCain–Palin 2008, "Straight Talk on Health System Reform."
5. For a more detailed discussion of this policy option, see Robert E. Moffit, "Choice and Consequences: Transparent Alternatives to the Individual Insurance Mandate," *Harvard Health Policy Review*, Vol. 9, No. 1 (Spring 2008), pp. 223–233.
6. State tax policies, with few exceptions, mirror federal tax policy for health insurance.
7. Joint Committee on Taxation, U.S. Congress, *Tax Expenditures for Health Care*, July 30, 2008, p. 5, at *http://www.house.gov/jct/x-66-08.pdf* (October 13, 2008).

als can contribute tax-free to an HSA. Those funds carry over from year to year without tax penalty and can be withdrawn without tax penalty to pay for qualified medical expenses.

Improving HSAs would reward individuals for choosing a low-premium plan by allowing them to deposit the remaining amount of their credit into a tax-preferred account to pay either for health care expenditures that are not met through the premium or for future costs, such as during retirement.

Fixing Federal Tax Policy on Health Insurance. The Senator's proposal to change the tax treatment of health insurance is the most critical and powerful reform in his health care plan.

As noted, liberal and conservative health policy analysts agree that existing federal policy is deeply flawed. The current federal policy is:

- *Unfair* because it penalizes Americans who do not or cannot obtain health insurance through their workplaces;
- *Regressive* because it disproportionately benefits upper-income individuals and families while providing little or no assistance to lower-income families;
- *Economically inefficient* because it undermines consumer choice and competition in the health insurance markets and fuels higher health care costs; and
- *An obstacle to labor mobility* because it undercuts portability of coverage in a highly mobile economy, thus undermining both continuity of coverage and continuity of care.

The McCain health care tax proposal would address these problems by:

- *Introducing universal fairness* into federal tax policy by giving individuals, regardless of work status, the same tax break for purchasing health insurance and by ensuring that lower-income individuals receive the full value of the credit by making it "refundable";
- *Changing the dynamics* in the health care system to control health care costs by encouraging individuals to secure greater value for their health care dollars; and
- *Linking health care tax breaks* directly to the individual rather than to the place of work, which would go a long way toward facilitating worker mobility and portability of coverage.

Tax equity and transparency. While the current tax treatment of health insurance provides unlimited tax assistance to workers who purchase coverage through their employers, it does nothing for workers and their families who do not or cannot obtain health insurance through their employment. No comparable tax relief is offered to workers outside the workplace.[9] Moreover, the tax exclusion is regressive, benefiting individuals at higher income levels substantially more than lower-income workers.[10] Under the McCain plan, individuals, regardless of work status, would receive the same tax break for purchasing health insurance.

Some critics claim that this transition from a tax exclusion to a tax credit—financing the credit by making health benefits taxable compensation like wages—would amount to a tax increase.[11] This is

8. For example, see John C. Goodman, "Making HSAs Better," National Center for Policy Analysis *Brief Analysis* No. 510, June 30, 2005, at *http://www.ncpa.org/pub/ba/ba518* (October 8, 2008); Michael F. Cannon, "Combining Tax Reform and Health Reform with Large HSAs," Cato Institute *Tax and Budget Bulletin* No. 23, May 2005, at *http://www.cato.org/pubs/tbb/tbb-0505-23.pdf* (October 8, 2008); and Nina Owcharenko, "Getting Health Savings Accounts Right," Heritage Foundation *WebMemo* No. 1127, June 14, 2006, at *http://www.heritage.org/Research/HealthCare/wm1127.cfm* (October 8, 2008).
9. The only other tax break allows individuals to deduct health care costs that exceed 7.5 percent of their adjusted gross income and allows the self-employed to deduct 100 percent of premiums.
10. Joint Committee on Taxation, *Tax Expenditures for Health Care*. See also Thomas M. Selden and Bradley M. Gray, "Tax Subsidies for Employment-Related Health Insurance: Estimates for 2006," *Health Affairs*, November/December 2006, p. 1573, and John Shiels and Randall Haught, "The Cost of Tax-Exempt Health Benefits in 2004," *Health Affairs*, February 25, 2004, pp. W4-106–W4-112, at *http://content.healthaffairs.org/cgi/content/full/hlthaff.w4.106v1/DC1* (October 13, 2008).
11. David N. Myers, "McCain's Tax Increase on Health Care," *The New Republic*, September 2, 2008, at *http://blogs.tnr.com/tnr/blogs/the_plank/archive/2008/09/02/mccain-s-tax-increase-on-health-care.aspx* (October 13, 2008).

incorrect. In fact, the proposed taxation of health benefits is simply a mechanism for transitioning from one tax break (the exclusion) to another (the credit). Under almost any scenario, the credit is a far more equitable and transparent tax policy.

Tax experts, regardless of philosophical persuasion, point out that the vast majority of Americans would be net winners with such a transition. Economist Len Burman, a tax policy specialist at the Urban Institute and Brookings Institution's Tax Policy Center, estimates that "[f]amilies at all income levels would pay lower taxes, at least on average.… On average, is about a $1,200 tax cut in 2009."[12]

A recent analysis by Republican congressional staff looked at the impact of transitioning from the exclusion to a credit on middle-class families. Assuming that the average annual value of employer-based family group coverage is roughly $12,000 and that those benefits were subject to income tax liability, a middle-class family in the 25 percent tax bracket would have a tax liability of $3,000 on those benefits. However, that family would be automatically eligible for a $5,000 health care tax credit, thus securing a $2,000 tax savings. A family in the 28 percent tax bracket would have a tax liability on the same health benefits package of $3,360, but the $5,000 credit would yield a tax savings of $1,640.[13]

Furthermore, the credit would help lower-income families. The analysis also found that workers in the lowest tax bracket would receive five times the tax benefits from a $5,000 family health care tax credit than workers in the highest tax bracket would receive. Even so, higher-income workers would still receive a slightly better tax benefit than they receive under the current system on the value (an estimated $12,000 annually) of the average group health insurance coverage.[14] The McCain tax credit is also designed to be refundable, meaning that individuals with little or no tax liability would still receive the full amount of the credit.

Transparency is also an important element of reform. Economists know that wages and benefits together comprise a worker's total compensation and that the employer's provision of health benefits offsets wages and other compensation. One measure to make this transparent for employees, protecting workers from a loss of compensation in any potential switch from an employment to a non-employment health plan, is for employers to disclose to their employees the value of the employees' health coverage and how that provision reduces their wages and other compensation. In this fashion, employees could secure appropriate wage increases or other compensation benefits that would accompany any transition from employer-based coverage.[15]

Of course, replacing the tax exclusion with a fixed and fair universal tax credit would introduce real transparency in the financing of health care. All Americans would receive the same tax break for buying health insurance. The tax benefits would no longer be hidden, and individuals would no longer be excluded.

Improving Value. Urban Institute scholar C. Eugene Steuerle argues that the existing tax exclusion encourages the purchase of more expensive health care policies, which increases the overall costs of health insurance. This makes coverage more expensive, pricing some individuals and families out of coverage and contributing to uninsurance.[16]

Today, workers have few incentives to consider health care costs, especially when they are under the erroneous but widely held impression that their

12. CBS News, "The Truth About McCain and Insurance Taxes," *Reality Check*, at *http://www.cbsnews.com/stories/2008/09/15/eveningnews/realitycheck/main4451525.shtml* (October 8, 2008).
13. See Andy Chasin and Chris Condeluci, "The Potential Benefits to the Middle Class from Health Care Tax Reform," memorandum to Republican health care and tax staff, September 11, 2008, p. 6.
14. *Ibid.*, p. 3.
15. See James Sherk and Nina Owcharenko, "How Bush's Health Care Tax Plan Will Raise Wages," Heritage Foundation *WebMemo* No. 1345, February 6, 2007, at *http://www.heritage.org/Research/HealthCare/wm1345.cfm*.
16. C. Eugene Steuerle, "Tax Reform: Prospects and Possibilities," statement before the Committee on the Budget, U.S. House of Representatives, October 6, 2004, p. 2, at *http://www.urban.org/UploadedPDF/900749_Steuerle_100604.pdf* (October 8, 2008).

employer simply pays for their coverage and that this coverage is somehow free to them.[17] The systemic consequences of this popular fiction are expensive. The perverse incentives created by this opaque economic arrangement are aggravated by the existing tax policy, which rewards those with a more generous health care plan by providing them with more tax-free benefits.

Overall, current tax law drives up health care costs. As the Congressional Budget Office (CBO) reports:

> The current tax exclusion for the costs of employment-based health insurance tends to cause more health spending to occur through that type of insurance—and more spending on health in general—than would otherwise be the case.[18]

Replacing the open-ended exclusion with a fairer, fixed tax break would make individuals more inclined to purchase insurance that offers them the best value for the dollars spent, whether through their employers or independently. This would introduce a level of market efficiency that is largely absent today.

In fact, coverage in the non-group market, where individuals purchase coverage without any comparable tax breaks, is less expensive than employer-based coverage. In 2007, the average cost of a family plan under employer-provided insurance was $12,106,[19] while the average family policy in the non-group market cost $5,799 and offered a broad range of benefits.[20] Today's tax policy effectively subsidizes increases in annual health care costs that routinely exceed the rates of inflation and wage growth.

The McCain proposal would also have the added benefit of encouraging employers to compensate workers by increasing their wages or other forms of compensation rather than by funneling more money to them as health benefits.[21] Replacing the exclusion with a credit and linking it to the consumer price index would help to moderate rising health care spending rather than acting as a catalyst for even higher health care costs.

Today's increasing health care costs are not inevitable. If consumers searched for value for their health care dollars—something they generally do not do today—they would reverse existing incentives that are driving up costs and would help to keep overall health care spending at a more rational level. As the Lewin Group, a national nonpartisan econometric health care firm, explains:

> By making employer health benefits taxable, consumers will have a new incentive to seek out lower-cost coverage. This would stimulate increased price competition among insurers resulting in increased enrollment in more efficient and lower cost-coverage.[22]

Breaking Job Lock. America has a highly mobile economy. For example, in 2007, there were 54.6

17. "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." Mark Pauly, "Blending Better Ingredients for Health Reform," *Health Affairs Web Exclusive*, September 16, 2008, p. w484, at *http://content.healthaffairs.org/cgi/content/full/hlthaff.27.6.w482/DC1* (October 8, 2008).
18. Congressional Budget Office, *An Analysis of the President's Budgetary Proposals for Fiscal Year 2008*, March 2007, p. 57, at *http://www.cbo.gov/ftpdocs/78xx/doc7878/03-21-PresidentsBudget.pdf* (October 8, 2008).
19. Henry J. Kaiser Family Foundation and Health Research and Educational Trust, "Employer Health Benefits: 2007 Summary of Findings," September 2007, p. 1, at *http://www.kff.org/insurance/7672/upload/Summary-of-Findings-EHBS-2007.pdf* (October 8, 2008).
20. America's Health Insurance Plans, Center for Policy and Research, "Individual Health Insurance 2006–2007: A Comprehensive Survey of Premiums, Availability and Benefits," December 2007, at *http://www.ahipresearch.org/pdfs/Individual_Market_Survey_December_2007.pdf* (October 8, 2008).
21. For a discussion, see Sherk and Owcharenko, "How Bush's Health Care Tax Plan Will Raise Wages."
22. Lewin Group, *McCain and Obama Health Care Policies: Cost and Coverage Compared*, October 8, 2008, p. 14, at *http://www.lewin.com/content/Files/The_Lewin_Group_McCain-Obama_Health_Reform_Report_and_Appendix.pdf* (October 10, 2008).

million job changes: 31.1 million workers quit their positions, mostly to change jobs; 19.7 million were laid off or fired; and 3.9 million left because of disability, death, or retirement.[23] According to the Department of Labor, the average person born between 1957 and 1964 has already had 10.8 jobs.[24]

The McCain plan would accommodate the mobility of a highly advanced economy, increasing productivity and particularly enhancing the ability of small businesses to grow and expand. Individuals would have a level playing field—undistorted by the tax code—to choose whether to select a health policy from their workplaces or from other sources.[25]

Today, leaving a job or changing jobs means leaving behind the health insurance provided at the place of work. Individuals who wish to take a better job, change careers, or leave the workforce to raise a family or to retire early take substantial risks. They may find themselves going without coverage, purchasing non-group insurance with substantial tax penalties, or giving up a well-developed relationship with a physician or medical specialist. This health insurance obstacle to labor mobility is sometimes called "job lock."[26]

Under the McCain plan, which links tax breaks directly to individuals instead of to their place of work, individuals would no longer feel obligated to stay with their employers simply because they need to keep their employer-based health insurance. If the worker lost a job, changed jobs, or retired early, he or she could buy an insurance policy and offset its cost with the McCain health care tax credit.

Delinking the current tax structure from employer-based health insurance would not necessarily end employer-based insurance. Under the McCain plan, employers would still be able to deduct the cost of offering health insurance, and that employer-based health insurance would remain an attractive option for workers for a variety of reasons.[27] The Lewin Group estimates that 6.4 million people would gain coverage through their employers under the McCain plan.[28]

Political Obstacles to Reform

Health care experts are in broad agreement on the inequities in the current tax treatment of health insurance. Yet that intellectual consensus has not translated into a similarly broad political consensus on Capitol Hill.[29]

Health policy analysts of different philosophical persuasions who have long championed similar changes in the federal tax code recognize the political difficulties of such a reform. Jason Furman, a health policy specialist at the Brookings Institution, has written extensively on the shortcomings of the federal tax treatment of health insurance and the trade-offs inherent under various reform proposals. He concludes that "policymakers would have to balance the benefits of a potentially better system against the risks of disrupting what works now."[30]

23. U.S. Department of Labor, "America's Dynamic Workforce: 2008," at *http://www.dol.gov/asp/media/reports/workforce2008/chapter1-07.htm* (October 13, 2008).
24. U.S Department of Labor, Bureau of Labor Statistics, "Number of Jobs Held, Labor Market Activity, and Earnings Growth Among the Youngest Baby Boomers," *Economic News Release*, June 27, 2008.
25. Employers' tax breaks would not be affected by the McCain proposals. For a variety of reasons, employers would still find value in offering and deducting the cost of coverage for employees, regardless of the change in the tax position of employee coverage. See Nina Owcharenko, "Addressing Adverse Selection Concerns Under the President's Health Care Proposal," Heritage Foundation *WebMemo* No. 1332, January 30, 2007, at *http://www.heritage.org/Research/HealthCare/wm1332.cfm*.
26. For a discussion of this phenomenon, see Jonathan Gruber, "Health Insurance and the Labor Market," in A. J. Kuyler and Joseph P. Newhouse, eds., *Handbook of Health Economics*, Vol. I (Amsterdam: Elsevier Science, 2000), pp. 654–655.
27. See Owcharenko, "Addressing Adverse Selection Concerns Under the President's Health Care Proposal."
28. Lewin Group, *McCain and Obama Health Care Policies*, p. ES-2.
29. The exception to this is the Health Care for America Act (S. 334), introduced by Senators Ron Wyden (D–OR) and Robert Bennett (R–UT). See Nina Owcharenko, "Lawmakers Should Approach the Wyden–Bennett Bill with Caution," Heritage Foundation *WebMemo* No. 1849, March 13, 2008, at *http://www.heritage.org/research/healthcare/wm1849.cfm*.
30. Jason Furman, "Health Reform Through Tax Reform: A Primer," *Health Affairs*, Vol. 27, No. 3 (May/June 2008).

However, what "works now" does not work for millions of uninsured American families.

Changing federal tax policy governing health insurance is real change, unlike the conventional health reform proposals that would largely preserve, expand, and further regulate the status quo. Politically, such fundamental change is quite different from merely accepting existing government and third-party payment arrangements as a given and filling in the gaps with more government funding and government programs.

Such serious and profound change would transfer control of health care dollars from third-party payers to individuals and families. In other words, it would introduce personal choice and genuine competition into the huge health care sector, where free-market forces are virtually absent, routinely disparaged, generally feared, and strongly resisted.

Compelling Health Insurance Companies to Compete

> *I would also allow individuals to choose to purchase health insurance across state lines, when they can find more affordable and attractive products elsewhere that they prefer. Opening up the health insurance market to more vigorous nationwide competition, as we have done over the last decade in banking, would provide more choices of innovative products less burdened by the worst excesses of state-based regulation.*[31]

Senator McCain's plan would allow individuals to buy a health plan for themselves and their families outside of the boundaries of their state's regulation. Essentially, this would allow individuals to decide which state-regulated market best meets their personal needs. This would make health insurance like virtually every other good and service in the national economy and introduce a level of consumer-driven competition that does not exist today.

Analysis. Health insurance markets, with rare and notable exceptions,[32] are not driven by the free-market forces of consumer choice and competition. Unlike other insurance markets and markets for almost every other commodity or service in the national economy, most individuals cannot buy health insurance outside of their state-regulated market. This limits their ability to shop for health coverage that best meets their specific needs because such plans may not be available in their states.

Health costs differ dramatically from state to state because of a variety of factors, including demographics, prevailing wages, and patterns of medical practice. State laws, rules, and regulations also affect the cost and availability of coverage in each state. In some states, legislators and regulators impose onerous and expensive requirements on health plans and benefits, such as mandates for specific health benefits and guaranteed issue with community rating.[33] Insurance overregulation and the near absence of competition can severely limit individuals' coverage options and result in higher premiums, pricing many people out of the health insurance market.

Senator McCain's proposal would not, as some critics erroneously suggest, totally deregulate the market.[34] Instead, it would allow individuals to choose among the various state regulatory structures when they buy their coverage, dramatically expanding the number of insurance options available to them. This would foster interstate competition while preserving each state's regulatory authority.

In many respects, the McCain policy is similar to legislation sponsored by Representative John Shadegg (R–AZ) and Senator Jim DeMint (R–SC).[35]

31. McCain, "Better Care at Lower Cost for Every American," p. 30.
32. Walton Francis, "The Political Economy of the Federal Employees Health Benefits Program," in Robert B. Helms, ed., *Health Policy Reform: Competition and Controls* (Washington, D.C.: AEI Press, 1983), pp. 269–307.
33. Guaranteed issue requires insurers to offer a product to every applicant. Community rating requires insurers to charge the same price to all applicants. Combined, these two regulations result in higher premiums for all, pricing many individuals out of the market.
34. David Cutler, "The McCain Critique: Out of Touch and Short of Ideas," *Health Affairs* Blog, September 25, 2008, at *http://healthaffairs.org/blog/2008/09/25/the-mccain-critique-out-of-touch-and-short-of-ideas* (October 13, 2008).
35. Health Care Choice Act of 2005, H.R. 2355 and S.1015, 109th Cong.

Their proposal would create new federal rules, but states would remain primarily responsible for regulating health insurance.

Besides expanding the health insurance options for millions of Americans, such a reform would broaden and intensify competition among health plans and medical providers. If a state's existing array of health insurance plans proved less competitive in providing value for consumers' dollars, state legislators and regulators would have an incentive to conduct a serious review of their health insurance regulations—an incentive largely absent from the current system.[36] The end result would strike a balance between states' regulation of insurance and preservation of flexibility for insurers to innovate, giving consumers better choices.

Such a competitive policy would also reduce the number of uninsured. Researchers at the University of Minnesota recently simulated how such a market change would affect the take-up rates of persons buying health insurance. In each scenario, the market change reduced the number of uninsured. In the best scenario, the number of uninsured was reduced by 17 million.[37] The researchers concluded:

> A national market would lead to substantial additional health care access which should lead to health improvements among the vulnerable populations who currently find health insurance unaffordable. In addition, development of a national market requires no additional federal resources other than support for legislation to permit the development of such a change to the U.S. health insurance market.[38]

Opening the health insurance markets to interstate competition combined with expanding the tax treatment of health insurance would reduce the total number of uninsured in America even more dramatically.[39]

Direct Help for the Hard Cases

> *I would improve the non-employer, individual insurance market by building on existing Health Insurance Portability and Accountability Act (HIPAA) protections for people with pre-existing conditions and by expanding support for guaranteed access plan (GAP) coverage in the states that would insure them if they are denied private coverage or only offered coverage at very high premium costs.*[40]

Under McCain's Guaranteed Access Plan (GAP), the federal government would work with governors and provide federal assistance to develop models for states to ensure that individuals who experience difficulty obtaining coverage would have access to health insurance. One model envisioned under this approach would be a type of high-risk pool, in which a state or states would provide insurance with reasonable premiums to uninsurable individuals. In the recent analysis by the Lewin Group, the GAP provisions would cost an estimated $235.4 billion over 10 years.[41]

The McCain plan also envisions expanding private coverage options available to Medicaid enrollees and veterans, who frequently have difficulty accessing the care that they need.

Analysis. The McCain proposal has the virtue of proportionality. It targets the specific problem of the hard-to-insure and the uninsurable without

36. For an analysis of the proposal, see Robert E. Moffit, "The Health Care Choice Act: Eliminating Barriers to Personal Freedom and Market Competition," Heritage Foundation *WebMemo* No. 1164, July 17, 2006, at *http://www.heritage.org/Research/HealthCare/wm1164.cfm*.

37. Stephen T. Parente, Roger Feldman, Jean Abraham, and Yi Xu, "Consumer Response to a National Marketplace for Individual Insurance," University of Minnesota, Carlson School of Management, June 28, 2008, p. 8, at *http://www.hsinetwork.com/National_Marketplace_7-21-2008%20FINAL_Blind.pdf* (October 8, 2008).

38. *Ibid.*, p. 11.

39. In this instance, Parente *et al.* simulated an interstate commerce provision combined with a standard tax deduction and found a 70 percent reduction in the uninsured for those earning less than $45,000. See *ibid.*, p. 10.

40. McCain, "Better Care at Lower Cost for Every American," p. 30.

41. Lewin Group, *McCain and Obama Health Care Policies*, p. 23.

severely altering or undermining the health coverage options for everyone else. Estimates vary, but the number of Americans who are considered uninsurable is in fact quite small.[42]

Conscientious state legislators often grapple with how to deal with these hard cases. These vulnerable populations consist mostly of poor or sick individuals who do not or cannot obtain health insurance because they are excluded from the market by underwriting or pre-existing conditions or because they are ineligible for government programs.

Senator McCain envisions a major and continuing role for state governments in expanding health care access and innovating in the delivery of health care services, particularly to vulnerable populations. Any federal assistance to the states should give them a high degree of flexibility in designing and implementing a guaranteed access program. While many states use high-risk pools to address the needs of the hard-to-insure, the interests of the uninsured would be best served by allowing states to experiment with various models. This would give states an opportunity to learn from each other in pursuing coverage strategies.

Any attempt to deal with the hard-to-insure should be done in a cost-effective fashion. States can provide coverage for difficult cases in a variety of ways that also can control health care costs and limit taxpayer exposure. For example, states could mainstream hard-to-insure persons into the statewide health insurance markets at standard rates through a statewide risk-transfer pool, financed entirely by the insurers themselves. Their costs could be absorbed and redistributed to affected insurers through this pool, operating as a "back end" risk-adjustment mechanism.

As developed by Heritage Foundation analysts, the state risk-transfer pool would "simply be a mechanism for evening out disparities among private plans by shifting a portion of the excess costs incurred by plans with above-average shares of expensive claims or patients to plans with below-average shares."[43] In this version of the statewide risk-transfer pool, the premium financing of risks ceded to the pool by the insurers would be private, with little or no financial exposure for the taxpayer.

Finally, reforming public health programs, as suggested by Senator McCain, to expand options for Medicaid enrollees and veterans is important. Opening access to private health insurance and integrating consumer-directed models would give these vulnerable populations more control of their personal health care decisions.[44]

Federalism. Identifying the key role that states play in health care reform is an important component of the McCain plan. The Senator recognizes that one-size-fits-all federal solutions cannot meet the unique needs of all Americans. He also recognizes that, although health reform requires a strong national dimension, different states will take different approaches.

Welfare reform provides a useful model. Experimentation by states provided federal policymakers with a better understanding of the federal obstacles to reform and the value of tailoring solutions to unique state conditions to meet broad federal goals. Given that no perfect federal solution exists, federalism offers a promising alternative. Heritage Foundation and Brookings Institution analysts have outlined a way to engage the states and advance health reform in a divided political environment.[45]

42. Estimates range from 2 million to 5 million. Thomas Miller, "Health Plan Scoring That Runs Out of Bounds," *Health Affairs* Blog, September 25, 2008, at *http://healthaffairs.org/blog/2008/09/25/health-plan-scoring-that-runs-out-of-bounds* (October 8, 2008), and Aliza Marcus, "Baby Kendra's $300,000 Bill Pains Insurers, Inspires Candidates," Bloomberg News, May 7, 2008, at *http://www.bloomberg.com/apps/news?pid=20601109&sid=a4BEIIi_OauQ* (October 1, 2008).

43. Edmund F. Haislmaier, "State Health Care Reform: A Brief Guide to Risk Adjustment in Consumer-Driven Health Care Markets," Heritage Foundation *Backgrounder* No. 2166, July 28, 2008, at *http://www.heritage.org/Research/HealthCare/bg2166.cfm*.

44. For a discussion on reforming public programs, see Nina Owcharenko, "A Road Map to Medicaid Reform," Heritage Foundation *Backgrounder* No. 1863, June 21, 2005, at *http://www.heritage.org/research/healthcare/bg1863.cfm*.

A Conventional Policy for Prescription Drugs

Senator McCain would open the U.S. market for safe drug importation and accelerate the use of generic drugs to lower the prices of prescription drugs.

Analysis. The Senator's drug importation proposal raises the same objections as similar proposals recently debated in Congress.[46]

America leads the world in drug development, and Americans benefit by having access to these life-saving drugs. However, Americans also shoulder a significant portion of the costs associated with developing these new drugs. Many foreign governments impose price controls on drugs, shifting development costs onto American consumers.[47]

The basic idea behind drug importation is to allow American consumers to import artificially low-cost drugs from price-controlled countries. While this sounds attractive, this concept has several inherent flaws.

First, it signals U.S. support for price-controlled markets, which could deter development of new drugs.

Second, drug importation depends on a safe distribution system. The Secretaries of Health and Human Services under Presidents Bill Clinton and George W. Bush could not guarantee the safety of imported drugs.[48]

Third, even if the federal government could guarantee safety and was willing to allocate significant resources to address safety concerns, there would be few cost savings. The CBO estimates that drug importation would save less than 1 percent in overall U.S. drug spending.[49]

In short, this policy may be politically appealing, but its likely results are less than clear.[50]

Furthermore, the debate on prescription drugs has changed in recent years. Drug importation was more pressing when a substantial number of senior citizens—roughly one out of four—did not have access to prescription drug coverage. This changed dramatically after enactment of the Medicare Modernization Act of 2003, which created a universal entitlement to prescription drugs in the Medicare program and provided a generous subsidy to low-income seniors. This makes drug coverage available to and far more affordable for seniors.

Since enactment of the Medicare drug benefit, projected average drug premiums have generally declined, although they are expected to increase in 2009. For 2009, the average monthly premium for the basic Medicare drug benefit is projected to cost $28 per month, far lower than the original projections of $37 per month. Additionally, Medicare beneficiaries in most states will be able to secure drug plans with premiums below $20 per month.[51]

45. Henry J. Aaron and Stuart M. Butler, "A Federalist Approach to Health Reform: The Worst Way, Except for All the Others," *Health Affairs*, Vol. 27, No. 3 (May/June 2008).
46. Nina Owcharenko, "Debunking the Myths of Drug Importation," Heritage Foundation *WebMemo* No. 542, July 20, 2004, at *http://www.heritage.org/Research/HealthCare/wm542.cfm*.
47. Merrill Matthews, "Riding the Coattails of U.S. Patents," Institute for Policy Innovation *Ideas* No. 27, June 4, 2004, at *http://www.ipi.org/ipi%5CIPIPublications.nsf/PublicationLookupFullText/E8C319D5BAF9DA2E86256ED6006CA1CD* (October 6, 2008).
48. Tommy Thompson, U.S. Secretary of Health and Human Services, letter to Senator James Jeffords (I–VT), July 9, 2001, at *http://www.fda.gov/oc/po/thompson/medsact.html* (October 8, 2008).
49. Congressional Budget Office, "Would Prescription Drug Importation Reduce U.S. Drug Spending?" *Economic and Budget Issue Brief*, April 29, 2004, p. 1, at *http://www.cbo.gov/ftpdocs/54xx/doc5406/04-29-PrescriptionDrugs.pdf* (October 6, 2008).
50. U.S. Department of Health and Human Services, Task Force on Drug Importation, *Report on Prescription Drug Importation,* December 2004, at *http://www.hhs.gov/importtaskforce/Report1220.pdf* (October 5, 2008), and Panos Kanavos and Paul Holmes, *Pharmaceutical Parallel Trade in the UK*, Civitas: Institute for the Study of Civil Society (London), April 2005, at *http://www.civitas.org.uk/pdf/ParallelTradeUK.pdf* (October 5, 2008).
51. Press release, "CMS Reminds Medicare Beneficiaries to Review and Compare Their Current Drug Coverage," Centers for Medicare and Medicaid Services, September 25, 2008, at *http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=3276* (October 8, 2008).

Beyond passage of the Medicare drug bill, there are stunning discounts available in retail markets[52] and private initiatives to help individuals obtain prescription drugs.[53]

Details of Senator McCain's proposal to speed up access to generic drugs are unclear. Use of generics has already increased significantly: 68 percent of all prescriptions are filled with generic drugs.[54]

The key issue in this case is the intersection of accelerated access to generic drugs, existing patent law, and drug innovation. If policy initiatives are not properly aligned, they can be counterproductive. Washington policymakers need to tread lightly to preserve a balance between expanding access to generic drugs and protecting intellectual property rights, which are vital to drug innovations.

Improving Health Care Delivery

Senator McCain emphasizes the need to improve health care delivery with the goal of securing better value for health care dollars at lower cost. The McCain initiatives in this area include:

- **Improving chronic disease care.** Senator McCain would emphasize prevention, early intervention, healthy habits, and new treatment models. He favors a new public infrastructure and expanded use of information technology in health care to provide better quality at lower cost for chronic conditions.
- **Supporting care coordination.** The proposal would entail a single payment for high-quality disease care as a way to make doctors and other medical professionals more accountable and responsive to patients for results.
- **Increasing transparency.** McCain would make information on medical outcomes, quality of care, and costs and prices more available to the public. In addition, his plan would facilitate national standards for measuring treatments and outcomes.
- **Expanding access to alternative care facilities.** The McCain plan envisions the federal government expanding access by promoting retail outlet clinics and walk-in clinics.
- **Using health information technology.** Senator McCain envisions rapid deployment of a health IT system based on federal guidelines.
- **Pursuing payment reforms.** McCain would reform the payment system used in Medicare and Medicaid and would compensate providers for diagnosis, prevention, and care coordination.
- **Enacting medical liability reform.** McCain would have Congress enact medical liability reform that eliminates frivolous lawsuits.[55]

Analysis. The McCain plan would promote disease management, care coordination, health information technology, transparency, liability reform, and pay reforms in government health programs for hospitals, doctors, and other medical professionals. The entire thrust of these initiatives is to secure higher value and better results for fewer dollars. These goals are undeniably beneficial to patients and inherently laudable.

However, these increasingly popular reforms raise two concerns.

First, McCain is often unclear in explaining exactly how these initiatives would be developed and implemented and what roles government and the private sector would play. In other words, they could be pursued and advanced in a way that is compatible with robust and dynamic free-market reforms in financing and the health insurance markets—which is clearly the objective of Senator McCain's financial and coverage initiatives—or they could easily become avenues for imposing increasingly prescriptive federal regulation, duplicating existing state regulation, and further undermining personal freedom in health care decisions.

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52. For example, Wal-Mart, Sam's Club, and Target provide such discounts. See Levi J. Long, "Target Joins Move to $4 Generics," *Arizona Daily Star*, October 20, 2006, at *http://www.azstarnet.com/business/151991* (October 10, 2008).
53. See Partnership for Prescription Assistance, Web site, at *https://www.pparx.org* (October 8, 2008).
54. Pharmaceutical Research and Manufacturers of America, "Sharp Decline in Prescription Drug Spending Growth," April 2008, at *http://www.phrma.org/files/Drug%20Spending%20Brochure%20FINAL.pdf* (October 8, 2008).
55. McCain–Palin 2008, "Straight Talk on Health System Reform."

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Prominent economists have pointed out that realigning the incentives of insurers, doctors, hospitals, and patients through a restructured market is the best way to deliver value to patients.[56]

Second, how these health care delivery initiatives would realize their attributed savings is unclear, largely because of the uncertainty surrounding their implementation and because of external factors that would determine their success as cost-saving innovations. As Professor Mark Pauly, a health care economist at the University of Pennsylvania, has observed:

> 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 receipt of preventive care, or full trust in primary care doctors who are custodians of a medical home….
>
> 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.[57]

Finally, involving government in the implementation of delivery reforms runs the serious risk of turning the initiatives into government tools to lower costs by limiting access to care and services, severely interfering with the care that patients receive.

Disease Management and Care Coordination. The need to improve quality and reduce costs for treating chronic conditions is not in dispute. The question is how a McCain Administration would achieve these goals.

How the payment of medical professionals would function under care coordination is a key area that needs to be clarified. It is reasonable to assume that these efforts on care coordination are intended to be broader than just government-run health programs. This is a matter of concern if it impedes the flexibility of innovative private health plans.

In a health insurance market that is increasingly driven by consumers' decisions, as envisioned under the McCain tax and insurance proposals, private health insurers would have a powerful economic incentive to keep patients healthy and costs low. However, government interference in a reformed private insurance market, which is already testing new models of care, could discourage further innovation by insurers to find and experiment with more advanced models that could improve the quality of patient care and keep costs down.

For example, the Senator emphasizes promoting the availability of smoking-cessation programs. Many private health insurance plans, including those in the FEHBP, already have such programs. It is unclear from his plan whether the McCain strategy would focus on government-run programs or is a new federal benefit mandate on private insurers, such as the proposed mental health parity initiative. Without specifics, it is difficult to determine how much decision-making with respect to care coordination would remain a private-sector responsibility.

Transparency. For most Americans, the health care sector of the economy is maddeningly opaque. Transparency, especially in cost and quality, is a laudable goal. The key question in the McCain plan is whether any proposed federal standard would eliminate or supersede nongovernmental efforts. Ideally, consumers should have access to multiple, competing sources of information on price and quality. Most important, the information should be a means for consumers, not government officials, to make better health care decisions for themselves and their families.

Alternative Facilities. Although short on details, the McCain plan would promote retail outlet clinics and walk-in clinics. It is difficult to imagine a useful

56. See Regina Herzlinger, *Who Killed Health Care? America's $2 Trillion Problem and the Consumer-Driven Cure* (New York: McGraw Hill, 2007). See also Michael Porter and Elizabeth Teisberg, *Redefining Health Care: Creating Value-Based Competition on Results* (Boston: Harvard Business School Press, 2006).

57. Pauly, "Blending Better Ingredients for Health Care Reform."

federal role in this area, particularly given the surge in the availability of such clinics and the increasing numbers of consumers using them.[58] Conceivably, his proposal could use federal control of government health plans to steer patients to these types of arrangements.

The government, however, should refrain from such efforts that choose winners and losers in the health care marketplace. With proper market incentives in a consumer-driven system, private health plans would likely adopt reimbursement strategies to promote such facilities. Economic demand driven by consumers, not government officials, should determine the market for these alternative facilities.

Health Information Technology. Health information technology unquestionably holds great promise for improving accuracy and safety in the delivery of medical goods and services, improving efficiency in health care payment, and moderating health care cost increases. Some analysts believe that IT could revolutionize the health care system. However, the CBO warns, "By itself, the adoption of more health IT is generally not sufficient to produce significant cost savings."[59]

The progress of health IT and the more widespread use of personal health records would be less problematic if the underlying economic incentives of health care were aligned more rationally than they are today. If individuals rather than government officials and corporate benefits managers were making the key economic decisions about plans and securing savings from those decisions, they would create a natural demand for higher efficiency and greater use of IT in health care transactions.

As consumers, individuals could purchase coverage based on the quality and effectiveness of medical services and ancillary benefits such as the provision of a personal health record. More consumers would demand that doctors and other medical professionals communicate with them using 21st century technology. In the banking and credit card industries, the use of consumer-friendly information technology is routine and evolving. Similar patterns of expansion and usage would evolve in a consumer-driven health care system.

Payment Reforms. The McCain plan proposes payment reforms in Medicare and Medicaid. While providers should put patients first, the current payment system, particularly under Medicare and Medicaid, rewards providers based on quantity rather than quality.

If the Senator is pondering the broader application of Medicare's proposed pay-for-performance scheme, which sets government guidelines for medical practice, then he is proposing a flawed solution. President Bush first introduced this concept in connection with reforming Medicare payments to physicians.

However, as designed for Medicare, federal pay-for-performance would result in doctors treating patients by using "cookbook medicine," which would undermine high-quality personalized care and weaken the doctor–patient relationship.[60] Even if initially limited to Medicare, this practice would likely spread because private health insurers regrettably tend to copy the Medicare payment regime.[61]

Medical Liability Reform. Senator McCain offers no specific medical liability reforms, but he does

58. John Goodman, "Health Policy Blog," National Center for Policy Analysis, September 30, 2008, at *http://www.john-goodman-blog.com/walk-in-clinics* (October 13, 2008).

59. Peter R. Orszag, "Evidence on the Cost and Benefits of Health Information Technology," testimony before the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, July 24, 2008, p. 11, at *http://www.cbo.gov/ftpdocs/95xx/doc9572/07-24-HealthIT.pdf* (October 8, 2008).

60. For an overview of the Medicare pay-for-performance proposal, see Richard Dolinar and Luke Leininger, "Pay for Performance or Compliance? A Second Opinion on Medicare Reimbursement," Heritage Foundation *Backgrounder* No. 1882, October 5, 2005, at *http://www.heritage.org/research/healthcare/bg1882.cfm*.

61. "If the biggest payer in the world sets out payment rules for all the providers, rules designed to minimize the bill as much as possible, and then requires all the providers to comply, by law, or go to jail, why wouldn't the smaller payers take advantage of that? They would, and they do. That does not make it good for the healthcare economy." Harry Cain, "The Medicare Menace," *Harvard Health Policy Review*, Vol. 2, No. 1 (Spring 2001), p. 19, at *http://www.hcs.harvard.edu/~epihc/currentissue/spring2001/cain.html*.

recognize that frivolous lawsuits are a fundamental problem. Regrettably, he suggests a federal solution, even though medical liability is primarily a state responsibility.

The impact of high medical liability insurance on access to critical services has already led many states to address the issue. States can enact effective caps on damage awards and pursue a variety of other remedies. Not only is this issue better suited to state remedies, but inevitable variation among state responses will provide an opportunity for states to learn from each other.[62]

Costs, Savings, and Coverage Under the McCain Plan

Accurately assessing the effects on costs, savings, and coverage is difficult because economists must often rely on assumptions. However, several prominent economists have provided analysis to help measure these policies.

The Lewin Group estimates that the McCain plan will cost $2.05 trillion over 10 years.[63] Analysts at the Urban Institute and Brookings Institution's Tax Policy Center estimate that the McCain plan would cost $1.3 trillion over 10 years.[64]

The Lewin Group also estimates that average family health spending would decrease by $1,411 under the McCain plan.[65]

There have also been various attempts to project the impact of the McCain plan on expanding coverage. The Lewin Group estimates that 21.1 million people would gain coverage under this plan.[66] Overall, the McCain plan would increase the number of people with private coverage by 26.5 million.[67]

Conclusion

Senator McCain's vision for health care reform is underscored by a principled commitment to personal freedom. He focuses on reforming the system to empower individuals and families to make health care decisions and to control their health care dollars.

At the cornerstone of his plan is reforming the tax treatment of health insurance, long a fundamental obstacle to promoting a more consumer-based health care system. The McCain plan would replace the current tax exclusion for employer-based coverage with a fairer, universal refundable tax credit that would enable Americans to purchase health care coverage of their choosing. The health care tax reform is coupled with a proposal enabling individuals to purchase health insurance from any state in the Union, dramatically expanding coverage options, and opening up interstate competition in health insurance. Finally, the McCain plan would establish a partnership with states to help address the insurance needs of hard-to-insure individuals.

The McCain plan also proposes a variety of delivery reforms, albeit with few details. It is critical that these reform efforts not lead to greater government interference in or control of the care and services available to Americans. Such efforts should enhance the role of choice and competition, which is at the heart of Senator McCain's policy agenda, not compromise the doctor-patient relationship or undermine personal choice.

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62. Randolph W. Pate and Derek Hunter, "Code Blue: The Case for Serious State Medical Liability Reform," Heritage Foundation *Backgrounder* No. 1908, January 17, 2006, at *http://www.heritage.org/Research/HealthCare/bg1908.cfm*.
63. Lewin Group, *McCain and Obama Health Care Policies*, p. ES-1.
64. Len Burman, Surachai Khitatrakun, Greg Leiserson, Jeff Rohaly, Eric Toder, and Bob Williams, "An Updated Analysis of the 2008 Presidential Candidates' Tax Plans," Urban Institute and Brookings Institution, Tax Policy Center, updated September 12, 2008, p. 53, at *http://www.taxpolicycenter.org/UploadedPDF/411749_updated_candidates.pdf* (October 10, 2008). Analysts with the Health Systems Innovations Network estimate a cost of $287 billion annually. Roger Feldman, Lisa Tomai, and Sally Duran, "Impact of Barack Obama 2008 Health Reform Proposal," Health Systems Innovations Network, August 21, 2008, p. 1, at *http://www.hsinetwork.com/Obama_HSI-Assess_08-21-2008.pdf* (October 10, 2008).
65. Lewin Group, *McCain and Obama Health Care Policies*, p. 42.
66. *Ibid.*, p. ES-1.
67. *Ibid.*, p. ES-4.