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The Obama Health Care Plan: A Closer Look at Cost and Coverage

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Presidential candidate Senator Barack Obama (D–IL) has put forth an ambitious health care plan.[1] The plan proposes:

- Expanding eligibility for existing public programs, including both Medicaid and the State Children's Health Insurance Program (SCHIP);
- Creating a National Health Insurance Exchange to serve as a federal regulator of private insurance plans that would compete alongside a new National Health Plan;
- Providing income-related subsidies for those without employer-sponsored health insurance while mandating that children have coverage; and
- Requiring that medium and large employers provide coverage or pay a tax, while extending tax credits to small businesses and creating a government reinsurance program to cover businesses' catastrophic health costs.

Differing Estimates. Analyzing proposals based on campaign documents and media accounts is inherently difficult, as these materials lack the level of detail necessary for a rigorous econometric analysis. Nonetheless, several organizations have done so, using a variety of assumptions and methodologies.[2] Most notable are the Lewin Group,[3] Health Systems Innovations Network,[4] and the Urban Institute-Brookings Institution Tax Policy Center.[5]

The best independent research shows that the Obama plan would cover roughly half of the 45 million uninsured through an expansion of public coverage; rely on soft methods of cost-savings; and require significant increases in federal expenditures.

Coverage. According to the Lewin Group, the Obama plan would reduce the number of uninsured by 26.6 million in 2010 if fully implemented in that year. The plan would also bring about significant shifts in sources of coverage. While 21.6 million people would lose their private health insurance, 48.3 million people are projected to obtain public coverage through Medicaid, SCHIP, or the new National Plan. Private employer-sponsored coverage would decline by 13.9 million, and private non-group coverage would decline by 7.7 million. Meanwhile, 18.6 million employees would buy into the new public plan through their workplace (as their employers switched to this plan from private coverage), 13.1 million individuals would buy into the public plan in the non-group market, and 16.6 million individuals would become newly enrolled in Medicaid or SCHIP. Therefore, the expansion of coverage under the Obama plan would be driven by enrollment in public coverage. This would entail a crowd-out of existing private non-group and private employer-sponsored insurance.

Estimates of sources of coverage, however, are sensitive to assumptions about the level at which

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provider reimbursement is set for the National Plan. The figures above are based on the assumption that the National Plan would reimburse providers at a level halfway between private market rates and the lower rates set by Medicare. In an alternative scenario modeled by Lewin, reimbursement was reduced to Medicare payment levels. Enrollment in the National Plan reached as much as 42.9 million, contributing to a 32-million-person decrease in private health insurance and a 60.1-million-person increase in public coverage. While sources of coverage would change significantly, there would not be a significant change in the net reduction of the uninsured.[6]

Lewin applied a type of model known as a *micro-simulation*.[7] Health Systems Innovations Network (HSI) conducted an analysis (funded by the McCain campaign) also using this type of approach.[8] It found that the plan would reduce the uninsured by 25.5 million. It also found that 24.6 million people would enroll in the new public plan through employers or in the non-group market. However, the HSI study did not look at the proposed expansions of Medicaid and SCHIP that would further increase enrollment in public coverage.

In contrast, the Tax Policy Center (TPC) applied a different type of model known as an *elasticity-based approach*.[9] The TPC estimated the Obama plan would reduce the number of uninsured by 18.4 million in 2009. In that year, 4.3 million people would gain employer sponsored insurance, 5.8 million would obtain non-group coverage, and 8.3 million would enroll in public coverage. The TPC did not take into account the differences in provider reimbursement between the National Plan and private insurance.[10] Moreover, the results are

1. Obama for America, "Barack Obama and Joe Biden's Plan to Lower Health Care Costs and Ensure Affordable, Accessible Health Coverage for All," at *http://www.barackobama.com/pdf/issues/Health careFullPlan.pdf* (October 23, 2008); for an analysis of the Obama plan, see Robert E. Moffit, Ph.D., and Nina Owcharenko, "The Obama Health Care Plan: More Power to Washington," Heritage Foundation *Backgrounder* No. 2197, October 15, 2008, at *www.heritage.org/research/healthcare/bg2197.cfm.*
2. See Kevin Sack, "On Health Plans, the Numbers Fly," *The New York Times*, October 21, 2008, at *http://www.nytimes.com/2008/10/22/us/politics/22health.html?hp* (October 23, 2008).
3. The Lewin Group, "McCain and Obama Health Care Policies: Costs and Coverage Compared," October 8, 2008, at *http://www.lewin.com/content/Files/The_Lewin_Group_McCain-Obama_Health_Reform_Report_and_Appendix.pdf* (October 23, 2008).
4. Roger Feldman, Lisa Tomai, and Sally Duran, "Impact of Barack Obama 2008 Health Reform Proposal," HSI Network, August 21, 2008, at *http://www.hsinetwork.com/Obama_HSI-Assess_08-21-2008.pdf* (October 23, 2008)
5. Len Burman et al., "An Updated Analysis of the 2008 Presidential Candidates' Tax Plans: Revised August 15, 2008," Tax Policy Center, updated September 12, 2008, at *http://www.taxpolicycenter.org/UploadedPDF/411749_updated_candidates.pdf* (October 23, 2008).
6. See Lewin, p. 21. Only 1.4 million would gain coverage in the alternative scenario compared to the initial scenario where payment levels were assumed to be at the midpoint between Medicare and private payer levels.
7. A micro-simulation is based on a utility-maximizing model of how individuals choose insurance plans, allowing for variation on a range of variables, including price and income. This type of modeling combines individual characteristics and behavior to estimate how each person, or subgroup, within a population would react to a policy change. However, micro-simulations face the possibility of selection bias, as they make a series of assumptions based on a small sub-population and then apply them to a larger group. Lewin used their Health Benefit Simulation Model (HBSM), a micro-simulation of the U.S. health care system developed by Lewin in 1989 and continuously applied and refined ever since. Lewin's work has been deemed "the gold standard of independent health-care analysis." See "A Liberal Supermajority," *The Wall Street Journal*, October 17, 2008, at *http://online.wsj.com/article/SB122420205889842989.html* (October 23, 2008). For a detailed description of the HBSM, see the Lewin Group, "Summary Description of the Health Benefits Simulation Model (HBSM)," January 29, 2007, at *http://www.lewin.com/content/Files/HBSMSummary.pdf* (October 24, 2008).
8. For a detailed description of the HSI micro-simulation model, see Roger Feldman et al., "Health Savings Accounts: Early Estimates of National Take-Up," *Health Affairs*, Vol. 24, No. 6 (2005), pp. 1582–1591, at *http://content.healthaffairs.org/cgi/reprint/24/6/1582* (October 24, 2008).

somewhat confusing because it is impossible to determine enrollment in the National Plan.

Cost. According to the Lewin Group, health care system-wide savings over the 2010–19 period would be about $571.6 billion. Since the plan does not fundamentally change incentive structures in the health care sector,[11] most of its anticipated savings come from various delivery system improvements common to Obama's and McCain's plans, ranging from health information technology to disease management. The effectiveness of these initiatives assumes major behavioral changes. As Professor Mark Pauly, a prominent health care economist at the University of Pennsylvania, explains:

> The main problem is that these [popular, common methods] 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…. 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.[12]

The efficacy of these "if only" savings has been seriously questioned by the Congressional Budget Office (CBO). The CBO has reported that evidence of disease management,[13] comparative effectiveness,[14] health information technology,[15] or prescription drug re-importation[16] reducing costs quickly and appreciably is lacking.

Obama says the reason people lack health insurance is that they cannot afford it. The Obama campaign, in an effort to "talk to people in a way they understand,"[17] made an audacious promise: The typical family would save $2,500 on premiums under the Senator's health plan. In calculating this figure, the Obama advisors relied on their own best-guess estimates of "if only" system savings at full implementation. In its analysis of the Obama plan,

9. An elasticity model applies the same measure of responsiveness (how consumers respond to changes in variables, such as insurance cost) to an entire population, but different groups within that population may have different individual levels of responsiveness to changes in the variable(s) of interest. A micro-simulation allows for variation among different individuals and groups. Like a micro-simulation, an elasticity-based approach also faces the possibility of selection bias, as the population to which the elasticity is applied may vary systematically from the population within which it is established. For example, there may be significant differences between consumers in the non-group market today and individuals who would lose group coverage and enter this market under a policy change.
10. E-mail communication with Surachai Khitatrakun, an author of the Tax Policy Center report, on October 15, 2008.
11. For a longer discussion see Joseph Antos, Gail Wilensky, and Hanns Kuttner, "The Obama Plan: More Regulation, Unsustainable Spending," *Health Affairs,* w462, September 16, 2008.
12. Mark V. Pauly, "Blending Better Ingredients for Health Reform," *Health Affairs*, Vol. 27, No. 6 (2008), pp. w482–w491, at *http://content.healthaffairs.org/cgi/content/full/hlthaff.27.6.w482/DC1* (October 23, 2008).
13. "There is insufficient evidence to conclude that disease management programs can generally reduce overall health spending." Douglas Holtz-Eakin, Director of the Congressional Budget Office, letter to Don Nickles, chairman of the Senate Committee on the Budget, October 13, 2004, at *http://www.cbo.gov/ftpdocs/59xx/doc5909/10-13-DiseaseMngmnt.pdf* (October 24, 2008).
14. "It would probably be a decade or more before new research on comparative effectiveness had the potential to reduce health care spending in a substantial way." Congressional Budget Office, *Research on the Comparative Effectiveness of Medical Treatments*, December 2007, at *http://www.cbo.gov/ftpdocs/88xx/doc8891/12-18-ComparativeEffectiveness.pdf* (October 24, 2008).
15. "By itself, the adoption of more health IT is generally not sufficient to produce significant cost savings." Congressional Budget Office, *Evidence on the Costs and Benefits of Health Information Technology*, May 2008, at *https://www.cbo.gov/ftpdocs/91xx/doc9168/05-20-HealthIT.pdf* (October 24, 2008).
16. "The reduction in drug spending from importation would be small." Colin Baker, "Would Prescription Drug Importation Reduce U.S. Drug Spending?" Congressional Budget Office, April 29, 2004, at *http://www.cbo.gov/ftpdocs/54xx/doc5406/04-29-PrescriptionDrugs.pdf* (October 24, 2008).
17. Kevin Sack, "Health Plan from Obama Spurs Debate," *The New York Times*, July 23, 2008, at *http://www.nytimes.com/2008/07/23/us/23health.html?scp=1&sq=cutler%20talk%20to%20people%20in%20way%20understand%20obama&st=cse* (October 24, 2008).

the Lewin Group projects that the average savings per family would be $426.

Lewin, HSI, and TPC all found that spending by the federal government would, on net, have to increase significantly in order to implement the plan.

Lewin projected that the Obama proposal would increase federal spending by about $1.17 trillion over the 2010–19 period.[18]

HSI estimates the Obama plan would cost $452 billion per year, or more than $6 trillion over a 10-year period.[19] The dramatic difference between this estimate and others is largely a result of HSI's assumption that under Obama's mandate to cover children, the federal government would subsidize virtually the full cost of coverage. Also, HSI finds that the employer mandate would add sizeable costs to the federal government.

The TPC projects the Obama plan would cost $1.6 trillion over 10 years. However, the TPC model did not account for any of the savings measures in the plan.

In May 2007, advisers to the campaign issued a memorandum to "interested parties" that estimated the plan's cost.[20] Under "best-guess" assumptions, the Senator's advisers estimated the plan's net cost at $50–$65 billion a year at full implementation. The memorandum then claimed any new cost could be covered by rolling back part of the Bush tax cuts. It is controversial because of both its cost and savings estimates,[21] and other analysts have called into question the memorandum's conclusions.[22] Since the Bush tax cuts are set to expire within two years anyway, they are not a viable offset, because beyond expiration they are built into the federal government's budget baseline. Complicating the matter further, repealing the Bush tax cuts early has already been proposed by Obama as potential source of revenue for a number of other policy initiatives.[23]

Expanding Government Control. The Obama plan would reduce the number of uninsured citizens, but it would not control costs in any significant way while demanding considerable increases in federal expenditures. Coverage expansion would be driven by enrollment in public plans in which the government would set benefit levels and provider reimbursement rates. Cost-savings would not come from fundamentally realigning economic incentives but would rely on dubious "if only" propositions related to changes in health care delivery.

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18. According to Lewin, the Medicaid expansion would cost $910.9 billion, the premium subsidies would cost $365.6 billion, the small employer tax credit would cost $77.9 billion, the reinsurance program would cost $419.2 billion, and there would be a total of $599.3 billion in offsets.
19. The 10-year cost assumes 7 percent medical inflation per year. While the proposal would altogether cost $452 billion a year, its parts considered alone would sum to an annual cost of $562 billion. These parts include costs of minimum benefits ($23.2 billion), community rating ($32.7 billion), the mandate for children ($211.7 billion), the employer mandate ($179 billion), the low-income subsidy ($44.3 billion), small business tax credits ($30.8 billion), and government reinsurance ($40.4 billion).
20. David Blumenthal, David Cutler, and Jeffrey Liebman, letter to interested parties regarding the Obama health care plan, at *http://www.nytimes.com/packages/pdf/politics/finalcostsmemo.pdf* (October 23, 2008).
21. Sack, "Health Plan from Obama Spurs Debate."
22. See Joseph Antos, "Obama's $2,500 Promise: Unhealthy moves," ***National Review Online***, October 10, 2008, at *http://article.nationalreview.com/?q=Zjk5YWE5Y2I3YTZmODQxODIxNmFiYTFmMGNjZDA3MmU=#more* (October 23, 2008).
23. Stuart M. Butler, "'Roll back the tax cuts': An exercise in shady financing," Heritage Foundation Commentary, July 26, 2008, at *http://www.heritage.org/Press/Commentary/ed072608a.cfm.*