Containing Health Care Costs

Two Presidential Proposals But Only One Realistic Plan

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Executive Summary

The growth in health care costs is one of the most pressing challenges facing the United States and our elected leaders in the coming years. Health care spending, which doubled between 1996 and 2006 and is expected to double again in the next decade, outpaces wage growth and inflation. This growth poses a serious challenge for the federal budget, family budgets, and employers’ profitability. Yet at the same time, our health care system is not delivering for all Americans. In 2006, America spent approximately $2.1 trillion on health care—even as more than 47 million individuals went without insurance and thus without access to affordable routine care.

Between 2000 and 2006, private health insurance premiums increased more than 90 percent. And the rising costs will only continue, putting increasing pressure on American families. Total spending is expected to double by 2016, when health care will be responsible for 20 percent of U.S. gross domestic product. In 2001–2002, approximately 13 million families, or 11 percent of all families, spent more than 10 percent of their incomes on out-of-pocket costs—an increase of 3 percentage points from 1996–1997. While costs rise, America is failing to take full advantage of the tools that could help contain costs, such as evidence-based medicine, health information technology, and preventative services, to name a few.

As a result, policymakers on both the right and the left have advanced health reform plans that feature measures designed to contain health care costs. The political rhetoric emanating from the leaders of the conservative and progressive movements sounds remarkably similar. Both sides emphasize a series of proposals that share similar tools for reducing costs, including health information technology, managing chronic care, improving quality, and increasing competition. Agreement on the problem of rising health care costs, however, does not translate to agreement on how to achieve those solutions. The underlying philosophical approaches stand in stark contrast to each other, and the ultimate results of these competing proposals would be very different.

Conservatives, including Sen. John McCain (R-AZ), the likely Republican presidential nominee, would attempt to control health care costs by moving the locus of health insurance coverage to the individual market. Individuals and families would assume greater risk for rising insurance premiums and would absorb greater responsibility for cost-sharing. This market-based approach would make radical changes to today’s health care financing system, but would not attempt to provide affordable coverage for all Americans.
Progressives, including Sen. Barack Obama (D-IL), the likely Democratic presidential nominee, propose to make group coverage more affordable and available to all, regardless of income or employment situation. By expanding coverage and ensuring access for all, progressive approaches to cost-containment tools, such as prevention, chronic care management, and improving efficiency, have the scope to truly affect health care costs. Progressive leaders have consistently offered clear, concrete steps toward achieving these goals, including dedicating the resources needed to make cost containment a reality.

Despite similarities in the rhetoric of lowering health care costs, there is a stark difference in the design and likely outcomes of the two plans. There is little evidence for McCain’s claim that conservatives’ health care reforms will address health care costs, which he has called, “the biggest problem with the health care system.” As this report explains:

McCain’s extreme plan will likely not contain health care costs

Sen. McCain’s plan asks the impossible of consumers—it asks them to drive down prices and improve quality through one-on-one interactions with insurance companies. Extensive research, however, consistently shows that the pooling of individuals into large groups is the most effective way to manage risk and promote efficiency. Insurers increasingly operate in an oligopoly, where purchasers of all sizes have decreasing influence. Requiring individuals to navigate the health insurance market by themselves will also carry very real costs. If everyone with employer insurance were to enroll in individual coverage, administrative costs would increase by $20 billion annually.

McCain’s lofty rhetoric is unmatched by details

An analysis of Sen. McCain’s plan shows that his cost-containment steps lack specificity—regardless of his efforts to camouflage his proposals with rhetoric about “freedom” and “responsibility” lowering costs. Beyond the rhetoric, there are few concrete steps for implementation in his plan, and almost no detail about the resources he would dedicate to the effort.

Coverage for all Americans is the fundamental way to contain costs

Current research suggests that the closer a health care system is to providing affordable coverage for all, the more successful it will be in achieving significant cost containment. By extending coverage to all, we can achieve efficiencies, end cost shifting and rationalize financing mechanisms. Given Sen. McCain’s refusal to provide health care coverage for all, any success he may have in cost-savings will be limited.
The progressive alternative

In contrast, progressive leaders have consistently offered concrete steps to making sure all Americans have access to affordable health care, and to help bring down health care costs. And progressive governors have led by taking proactive action when possible, as this report shows. Indeed, for his part, Sen. Obama has articulated clear steps to implement his cost containment measures.

In addition, Sen. Obama is committed to covering all Americans by building and improving on the current system. Those steps would be far more likely to achieve the cost-containment goals that Sen. McCain just talks about. As this paper will detail in the pages that follow, there is no cost-containment panacea in health care, but the strategies proposed by progressive leaders have a better chance of success than those in the McCain plan.
Introduction

As health care costs rise, policymakers on both the right and the left have included measures aimed at containing health costs as a part of their reform plans. On a superficial level, the leaders of the conservative and progressive movements, the likely Republican and Democratic nominees for president, appear to offer strikingly similar ideas. Each outlines a series of proposals, including health information technology, managing chronic care, improving quality and increasing competition.

Despite superficial similarities, however, there is a stark difference in the design and likely outcomes of these two plans. The following analysis examines recent trends in the growth of health care costs, and assesses the competing plans’ ability to change these trends. In particular, this paper examines the plans’ fundamental theories for cost-control, some of the specific cost-control strategies delineated in these proposals, and the influence the overall scope and reach of a health care proposal can have on its capacity to control costs.
Background: Today’s Growing Health Care Costs

Health care costs in the United States have been growing rapidly in recent years. In 2006, the most recent year with available data, the total price tag for our health care system was $2.1 trillion. American spending on health care doubled between 1996 and 2006 and is expected to double again in the coming decade. To put those increases in perspective, growth in health spending has consistently outpaced growth in U.S. gross domestic product since 1998. Unsurprisingly, the number of insured Americans decreased by more than 21 percent between 1999 and 2006.

Rising health care costs are an increasing problem for both individuals and businesses. Between 2000 and 2007, the number of employers who provide health insurance for employees dropped almost 9 percentage points. Over that same period, premiums for private group health insurance nearly doubled—growing four times faster than wages. In 2001–2002, approximately 13 million families, or 11 percent of all families, spent more than 10 percent of their incomes on out-of-pocket costs—an increase of 3 percentage points from 1996–1997.

Similarly, out-of-pocket costs for families increased by 35 percent between 1996 and 2002, vastly outpacing the 19.5 percent growth in family incomes in the same period. And a major international consulting firm projects that the cost of health insurance for the largest U.S. companies will exceed profit levels for this year.

These rising costs have profound consequences for American workers and businesses as well as the national economy. General Motors Corp.’s widely quoted anecdote that employee health care benefits represent a larger portion of the production cost of a new car than the steel used to build the car captures the problem succinctly for most of corporate America. Growing health care costs restrict the funds available to American businesses for infrastructure investments, new hires, and general business development.

Employers paid $623.5 billion for health benefits in 2006, the last year for which complete data is available. These payments represented nearly 44 percent of total benefit payments, including Medicare, Social Security, and workers’ compensation payments, as well as retirement benefits and health coverage. Group health insurance premiums, which totaled $537 billion in 2006, represented 58 percent of voluntary benefits—and are growing more quickly than any other benefit category.
As health care premiums rise, and as health care benefits absorb a larger portion of benefit package costs and total worker compensation, businesses have struggled to cope with rising costs. Small businesses in particular are eliminating health benefits for employees. The percentage of small employers offering health insurance fell to 59 percent in 2007 from 68 percent in 2000.\textsuperscript{15} From 2000 to 2006, only 48 percent of companies with three to nine workers offered coverage over this same period.\textsuperscript{16}

The federal government is under similar pressure. Spending on Medicaid and Medicare tripled over the past three decades to about 4 percent of GDP, and is expected to equal roughly 12 percent of GDP by 2050 based on current spending. Should costs increase—and they are expected to—spending could reach as much as 17 percent of GDP by 2050.\textsuperscript{17}

**Background: Sen. McCain and Sen. Obama’s health care plans**

The conservative and progressive candidates for president offer strikingly different approaches to tackling the nation’s health care crisis. Sen. McCain’s plan places significant emphasis on moving the focus of health insurance coverage from group coverage, which is typically offered through employers, to coverage purchased in the individual market. To this end, he would remove the existing tax preferences for employer-sponsored coverage, substituting a tax credit, worth $2,500 per individual and $5,000 per family, to be used for the purchase of health insurance.

Sen. McCain would also significantly change current insurance rules by permitting health insurers to sell policies across state lines, thereby enabling insurers to locate their businesses in states with the most permissive regulatory schemes, while selling policies on a national basis. Under his plan, individuals with pre-existing conditions who cannot find affordable coverage in the individual market could purchase coverage through state-operated high-risk pools. Sen. McCain’s plan also includes cost control features, among them malpractice lawsuit reforms, investments in health information technology, prevention and disease management, and greater information on treatment options and provider performance.

Sen. Obama, in contrast, proposes to make existing group coverage more affordable and available to Americans by building on and improving the current system. Major features of this plan include expanding eligibility for the Medicaid and State Children’s Health Insurance Plan, or SCHIP programs; enabling small businesses and individuals to purchase coverage through a National Health Insurance Exchange, which would broker coverage in private plans or a new, national public plan; and providing income-related help with premium costs. He would require all employers to either offer coverage or contribute to the cost of the public plan, with tax credits for small business, and would require all parents to insure their children.
Sen. Obama also proposes changes to private insurance coverage, including requiring all insurers offer coverage to all applicants, regardless of medical condition, which is known as “guaranteed issue.” Sen. Obama would also establish minimum loss ratios in markets with inadequate competition between insurers, which would require insurers to spend a specified proportion of premiums on medical care, rather than administrative costs or profit.

Cost-control strategies in Sen. Obama’s plan include, but are not limited to, investments in health information technology, evidence-based medicine, prevention, chronic disease management and public health, strategies to address health care disparities, and transparency.
McCain’s extreme plan may not successfully contain health care costs

Sen. McCain’s extreme version of free-market ideology leads him to believe that individual consumers can create a health insurance market that is more cost conscious than the current employer-based purchasing system. His plan asks consumers to bear greater risk for medical costs, which is supposed to lead to greater competition among providers and insurers, ultimately lowering overall health care spending. His plan also envisions more consumer choice, by releasing health insurers from abiding by the regulations in the states where enrollees live and instead allowing them to adopt the rules of the state that they most favor.

Instead, this laissez-faire approach to regulation would weaken the ability of consumers to obtain the health care they need. Transferring more of the financial burden and more of the risk to individual consumers is unlikely to contain health care costs and could increase costs. The reasons:

- **Consumers lack bargaining power against health insurers.** Individuals have little chance of negotiating successfully with large health insurers. In fact, many health insurance markets today are dominated by a single insurance carrier, which disadvantages even large employers. Sen. McCain would leave individuals and families on their own—and with even fewer consumer protections.

- **Consumers lack the information needed to be effective purchasers.** There is little information available to patients to compare the cost and quality of providers and treatments, and what information exists they are unlikely to trust or use. In addition, Sen. McCain’s plan to contain costs by shifting risk to individuals ignores the fact that most health care spending is generated by a small group of the very sick who are less likely to be overusing care.

- **Consumers lack ability to avoid paying for increased administrative costs.** By expanding the inefficient individual market, Sen. McCain’s plan could actually increase administrative costs in health care by as much as $20 billion per year as insurance companies engage in more expensive marketing, underwriting and paperwork. Higher administrative costs will inevitably translate to higher consumer costs.
These three overarching problems with Sen. McCain’s plan to contain health care costs, alongside the one common characteristic of costing consumers more than they now pay, is even more evident when you delve further into the details of his plan.

**Consumers lack bargaining power with insurers**

It is difficult to imagine market dynamics that would allow individuals to drive down the cost of health insurance as Sen. McCain suggests. Indeed, some of the largest companies in America have decided that they would get a fair deal if they joined together. Case in point: An organization of benefit managers for major U.S. businesses recently announced their support for regional purchasing pools so that employers can come together and increase their leverage in purchasing insurance for their employees. At their meeting in Washington D.C., the president of the ERISA Industry Committee (which includes hundreds of major employers such as 3M Co., Lockheed Martin Corp., and ExxonMobil Corp.) stated that, “even large companies don’t have much negotiating power when facing large health plans.”

In fact, insurers already have substantial market strength today. In 299 of 313 health insurance markets recently surveyed, a single commercial health insurer (across all product types) controls at least 30 percent of the market (bounded as a metropolitan statistical area). In 16 states, a single commercial health insurer covers half the entire commercial state market; in 38 states, the insurer covers a third of the market.

**Consumer strength is weakened by growing the individual market**

Noting that individuals have limited market power, a study of the health care marketplace in specific communities has led some economists to develop, “a deep skepticism about the ability of market-based reforms” to change the health care system. Indeed, researchers have long concluded that individuals face difficult barriers in the insurance marketplace. Insurers create barriers to avoid potential enrollees who are likely to incur significant health care bills. Those barriers include:

- Underwriting, or the practice of investigating an insurance applicant’s medical history to determine their risk level and the rate they will be charged for insurance
- Experience-rated premiums, or the practice of charging higher premiums to individuals with medical conditions
- Rescission, or the practice of performing post-claims underwriting on a current policyholder, generally after they have submitted a claim for care, in order to possibly deny coverage based on health status or technical flaw in the insurance application.
It is the large purchasers of health care, such as large employers and state and federal government agencies, which have more clout to insist on cost and access concessions from insurers. A large group is generally able to reflect a balanced cross-section of risks—healthy enrollees who use fewer health services and are at low risk for expensive health spending alongside unhealthy enrollees who heavily use health services and are at high risk. Approximately 10 percent of the population accounts for 70 percent of health care spending; a large group ensures that enough healthy people pay premiums to balance out the costs of this expensive top 10 percent. Balancing high- and low-utilizers of health care services smooths out expected costs across the group, thus creating a stable insurance pool and easily predictable insurance costs.

A key attribute of employer-based health insurance, for example, is its power to aggregate healthy and unhealthy enrollees into large groups. Because employers hire and retain workers based on their job skills and performance, not their health needs, this pooling function generally establishes relatively stable groups of enrollees, spreading the financial risk of poor health or a catastrophic event across a large base of individuals. Employment provides the “glue” that binds the pool together. Actuaries, in turn, are able to develop relatively accurate predictions of future health care costs, which means premium costs will be more stable over time—in contrast to the wild premium fluctuations that smaller groups often experience.

In addition to greater premium stability, large employers are also able to find coverage at more favorable rates. They seek and purchase coverage uninhibited by the exclusionary practices that characterize the small group market, as their inherent stability and predictability is attractive to insurers. What’s more, analysis of health care spending reveals that small companies with fewer insured employees actually represent particularly favorable health risks, which suggests that insurers have effectively identified and selectively insured firms with low expected health care costs.

The upshot: higher prices in the small group market reflect the comparative disadvantage that small employers face when they seek to purchase coverage for their employees. This problem also applies to individuals, who more acutely feel the disadvantage of their small purchasing size and face the greatest barriers to obtaining coverage.

**McCain plan will reduce consumer protections**

The economic barriers to creating competition in the individual market are daunting because of the asymmetrical power relationship between the individual purchaser and the insurer. Individuals are not in a position to dictate insurance terms for one simple reason: The combined market capitalization of the top five health insurers is almost $100 billion. There is little reason to think that, in the growing economic oligopoly of health insurance, an individual purchaser can have any influence at all when the average employer-sponsored insurance policy for a family already costs $12,000 a year.
Sen. McCain has said that he wants a marketplace where insurance companies compete for individuals, including those with chronic conditions. Yet insurers’ profit margins rely on their ability to manage their risk pools, which can often translate into determined efforts and practices in the individual market to avoid risk. Insurers will seek to minimize their risk and financial exposure. Some insurance industry analysts do not believe that unregulated competition among plans can even occur.

To combat the insurers’ clear business interests, all 50 states and the federal government, to varying degrees, regulate health insurance today. Clearly, today’s regulated system has holes. There are examples of insurers that have pursued business strategies at risk of regulatory penalties, for example:

- PacifiCare, now a member of the UnitedHealth Group, is facing fines of up to $1.3 billion for wrongly denying claims.

- UnitedHealth Group, parent company of PacifiCare, and other insurers are also facing legal actions from New York Attorney General Andrew Cuomo for overcharging patients who received care from out-of-network doctors.

- Another California health plan, Health Net of California, was found to have rewarded employees with bonuses for succeeding at retroactively canceling coverage for policyholders who submitted expensive claims for care.

Despite this, Sen. McCain’s plan actually weakens the strength of individuals to purchase health insurance that offers sufficient coverage at a reasonable cost. Specifically:

- **McCain’s plan could reduce employers’ role, even though they play a critical function in supporting consumers.** Large employers today employ benefits managers to compare price, benefit packages, and other variables when selecting health insurance companies, which gives them greater ability to select high-value, lower-price coverage. Employers, particularly large employers, also can employ benefit professionals to help workers understand their options. Under Sen. McCain’s plan, employers may lose the incentive to provide coverage to their employees.

- **McCain’s plan to sell insurance products across state lines would increase consumer confusion.** For consumers to boast purchasing power in health insurance markets, they need a better understanding of the products available and how well each product meets their individual needs. Allowing products to be sold across state lines, as Sen. McCain proposes, would likely increase the complexity of plan standards, according to the varying regulatory authorities, making understanding the plans all the more difficult.

- **McCain is opposed to individual market protections.** When recently asked about requiring insurers to cover persons with pre-existing conditions, he responded, “That would be mandating what the free enterprise system does.” An alternative way to help level the playing field between those who buy health insurance and those
who sell it are anti-trust regulations addressing market mergers, but Sen. McCain’s health plan makes no mention of this approach.\textsuperscript{38}

\textbf{McCain plan ignores lack of information available to consumers}

Containing costs through Sen. McCain’s consumer-directed health reform relies on patients having and using information about care to make cost-effective choices. While consumers regularly use easily accessible cost and quality information in making purchases for such things as electronics and automobiles, the same is not true in health care. It is unlikely that America could see real cost savings through reforms that rely on individual patients to make cost-effective choices. Indeed, in many ways, Sen. McCain’s approach misses the point entirely. Specifically:

- \textit{Patients lack access to useful provider cost and quality information.} Patients simply do not have the information or tools they need to make informed decisions about their medical care.\textsuperscript{39} A 2005 survey, for example, found that just 14 percent to 16 percent of adults with insurance had access to quality information about their doctors and hospitals from their health plans, with a similar percentage having access to cost information.\textsuperscript{40} Given the limited information available today, some researchers suggest that it is dangerous for patients to make health care decisions under the current system.\textsuperscript{41} The U.S. health system needs easily understandable cost and quality data, but Sen. McCain’s plan fails to specify steps that will overcome the barriers in today’s system that have blocked the availability of such data.

- \textit{Patients cannot use cost and quality information effectively.} Most research indicates that U.S. patients do not have the health literacy skills needed to interpret the information available.\textsuperscript{42} In part, this is because Americans have virtually no experience using cost and quality information from sources such as health plans or the government.\textsuperscript{43} As a result, consumers typically neither trust nor use neutral cost and quality information from the government and health plans.\textsuperscript{44,45} In contrast, health industry officials—providers and payers—are more likely to use cost and quality information,\textsuperscript{46} and the reporting of such data can lead to improved quality.\textsuperscript{47}

- \textit{Health care costs are concentrated among a few patients.} Even if more patients took advantage of what information on cost and quality is available, consumers are still unlikely to rein in costs on their own.\textsuperscript{48} This is because health care spending is highly concentrated. Most health care spending in America is generated by the very sickest patients—1 percent of the population is responsible for about 25 percent of total expenditures while 50 percent of the lowest spenders accounted for only 3 percent of expenditures.\textsuperscript{49} These costly patients are those most in need of the care they are receiving—often under emergency or life and death situations. They are the patients least likely to be able to determine if they are overusing care, or to be able to “shop around” for the best deal.
Shift to individual market insurance could increase costs

Sen. McCain’s health care plan would further encourage the growth of what are already the fastest growing costs in our health care system: administrative costs. His plan would do this by expanding the inefficient individual market, where administrative costs are significantly higher, as well as increasing number of high deductible plans and Health Savings Accounts.

The inefficient individual market

Sen. McCain’s focus on the individual market brings with it significant new administrative costs. The individual health insurance market has much higher administrative burdens than the group market, where most Americans currently receive health insurance. The group market allows for economies of scale, and for risk to be spread across large pools of policyholders. The administrative costs are higher in the individual market as insurers have higher costs.

Administrative costs in the group market consume just 12 percent of premium dollars, which is less than half the administrative cost paid by policyholders on the individual market. There, the Congressional Budget Office estimates an average of 29 percent of premium payments are spent on administrative costs.

Moving individuals who currently receive insurance on the group market to the individual market could increase administrative spending by more than 20 percent—generating new costs of up to $20 billion per year.

Some of the reasons why costs are higher in the individual market include:

- **Underwriting.** Individual health status matters less on the group market as risk is spread broadly across large groups. In all but five states, insurers on the individual market conduct expensive research on the health status of applicants to determine which applicants pose too high a risk of needing care to be insurable.

- **Rescission.** Also called post-claims underwriting, insurers conduct more, and expensive, medical reviews of policyholders on the individual market, usually after they submit claims for care. The purpose of this research is to find evidence of a pre-existing condition to provide a pretext for the insurer to retroactively deny coverage to the individual. In addition to the expense of the medical research, insurers also spend large amounts on legal fees to enforce the rescissions.

- **Marketing.** Insurers on the individual market must advertise to a larger group of potential customers than insurers on the group market, who generally only target human resource departments. With more Americans seeking coverage on the individual market, health plan advertising may become more aggressive and costly, much like recent trends in pharmaceutical marketing.
Paperwork. In the group market, insurers and employers find economies of scale in recordkeeping for larger numbers of policyholders. On the individual market, there is a greater paperwork burden to track each individual policyholder.

New financial bureaucracy

While conservatives such as Sen. McCain rail against the creation of new government bureaucracies to administer “socialized” medicine, they are not acknowledging the new bureaucracies created by conservative health reform policies, such as Health Savings Accounts, or HSAs. The benefits of HSAs will likely accrue to financial institutions and the wealthy, not most lower- and middle-class Americans or patients in need of ongoing medical care.

Windfall for financial institutions. The growth of HSAs would likely generate growth in health care banking, with its attendant fees and asset and account management costs. One estimate put potential revenue from financial institutions managing HSAs over the coming five years at $3.5 billion, with an additional $2.3 billion in revenues for companies that process medical payments.

Tax breaks for the wealthy. Contributions and expenditures through HSAs are tax-free, offering wealthy investors both a tax shelter and investment tool, and are increasingly used in long term tax planning. In talking about President Bush’s promotion of HSAs, which closely resembles Sen. McCain’s effort, health economist Jon Gruber at the Massachusetts Institute of Technology says “the new tax breaks would be expensive and regressive, offering the largest benefits to the highest-income taxpayers.”

Increasing debt for patients. While high-deductible health plans are designed to be linked with HSAs, not all such policyholders can or do build up savings in an HSA to cover unexpected health care costs. This has led to an increase in the use of health care credit cards, which often have interest rates as high as 27 percent, to cover high deductibles.

Shifting costs to employees. A key benefit of high-deductible health plans and HSAs is that the monthly premium cost for employers, and employees, is often significantly less than more traditional plans. This shifts the cost of basic care to employees, who pay for all care before the deductible is met, and reduces employers’ financial support of the health care system overall.

Progressives promote effective market competition

Progressive health care reform advocates particularly stress two major strategies for controlling health care costs. First, they seek to harness the market power of group purchasing to provide more affordable coverage to small businesses and individuals with-
out access to employer-sponsored (or other group-based) coverage. Through insurance “exchanges” or other strategies for amassing individuals into larger risk pools, progressives would use market approaches to give small purchasers and individuals greater clout vis-à-vis insurance companies.

These small purchasers would enjoy greater choice of health plans, greater choice of provider networks, and lower premiums than they experience today. Insurance exchanges or other types of managed insurance markets would require plans to compete on price and consumer satisfaction, and would protect consumers from turning, in desperation, to plans with excessive cost sharing.

Second, progressives identify a set of key investments designed to improve the value of coverage today and to reduce health care costs in the future. These investments, which emphasize prevention, improved information on effective treatments and procedures, and enhanced use of information technology, would ensure that Americans receive greater value for each dollar of health care spending.

The details of these progressive investments to reduce health care costs are presented in our four appendices at the end of this paper. Some of these approaches are also part of the health reform plan of the Center for American Progress and other progressive thought leaders.

**McCain rhetoric unmatched by details and outmatched by progressive details**

While there is no silver bullet to addressing health care costs, the policy details and commitment of resources by policy leaders will be key determinants of America’s ability to contain costs. While there are many examples of progressives taking the lead on implementing real reform, Sen. McCain seems to offer more rhetoric than commitment. While there are many important areas of cost-containment policy, here are five key areas where Sen. McCain has offered few details on implementation in contrast to progressive leadership:

- **Promoting effective care.** High-quality care does not have to mean high-cost care. Ensuring that Americans receive the appropriate, quality care they need, when they need it, can reduce unnecessary care and medical errors. Sen. McCain has made general statements about the need to follow ‘best practices’ in medicine, but has not articulated any steps for making this happen.

- **Addressing health care disparities and chronic illness.** Research shows that certain groups of people are more likely to receive poor care, particularly minorities, low-income individuals and non-English speakers. Further, minority populations are more likely to have chronic medical conditions in need of regular medical attention. Sen. McCain’s plan includes no reference to how he would help reduce disparities in the quality of care many Americans receive.
- **Using health information technology.** Health information technology may be able to both reduce administrative waste and raise quality of care for individuals. Yet perverse financial incentives in the current health care market, as well as a lack of national standards, prevent Americans from benefiting from the efficiencies of health information technology. Sen. McCain’s plan offers no concrete support for health information technology.

- **Promoting prevention.** Transforming America’s health care system from one that treats illnesses to one that prevents most medical conditions could create significant cost savings. While Sen. McCain has expressed support for prevention, his plan would likely reduce preventive care by shifting its cost onto consumers through high deductible health plans, and by reinforcing perverse financial incentives in the insurance marketplace as consumers switch plans more often.

- **Creating incentives for greater quality and cost transparency.** An important first step toward making health system improvements is promoting transparency of costs and quality. While Sen. McCain has acknowledged the need for national standards to allow for better measurement, his plan relies on voluntary reporting that does not represent a change to the current patchwork system.

An examination of each of these five problems with Sen. McCain’s health care plan in more detail reveals the depths of his empty rhetoric on these issues and highlights the alternatives offered by progressives such as Sen. Obama, which we juxtapose below.
The United States could reduce costs and ensure that more patients receive the appropriate, effective care for their medical conditions by investing in critical comparative research, creating evidence-based medicine standards, and educating providers. Today, Americans are likely to receive the appropriate care just half of the time, and approximately one-third of individuals seeking care are likely to experience a medical error such as a medication mistake or the wrong lab results. This quality chasm has both a human and a financial cost. While work here is relatively new and the analysis can be complex, studies have shown that high-quality, effective care does not have to come with a high price tag. Improving quality could help save lives and contain costs. Estimates of savings go as high as 150,000 lives and $100 billion every year.

Today, our health care system spends significant amounts of money on treatments of unknown value because we lack a truly objective source of information on the effectiveness of many treatments. One example of this is Avastin, one of the most popular (and costly) cancer drugs in the world. Even as new studies are conducted on the drug showing it to be less effective than originally believed, the drug continues to be treated like a “miracle drug.” Little is actually known about other expensive medical treatments, such as computed tomography, or CT scans, which are not regulated by the Food and Drug Administration, and are not required to undergo any research to prove their benefit to patients.

Unfortunately, we know little about the quality and effectiveness of different medical treatments or the many new and old drugs and medical equipment. Today, there also is little to no head-to-head testing of drugs to see which are more effective. This is true despite a finding by the Congressional Budget Office that “generating additional information about comparative effectiveness and making corresponding changes in incentives would seem likely to reduce health care spending over time—potentially to a significant degree.” Having better information in and of itself may not be a sufficient condition for improving medical decisions, but it is necessary condition.

McCain’s position on promoting effective care

Sen. McCain’s health plan says that “We should dedicate more federal research to caring and curing chronic disease,” which may or may not include comparative effectiveness research. Sen. McCain has also said he wants to make Americans “more capable of making their own decisions” in order to help them “decide against unnecessary
options.”77 For physicians, he makes the general statement that we should “use technology to share information on ‘best practices’ in health care so every physician is up-to-date.”78 His plan, however, provides no explanation on how to encourage needed research or implementation.

Progressive leadership on effective care

Several progressive governors are taking a leading role in creating state-level agencies designed to promote evidence-based medicine, with the understanding that compiling information isn’t enough—the information has to be relevant and available for providers. Many of the initiatives are designed specifically to improve the treatment of chronic care, a top health care cost driver. The North Carolina Quality Health Care Alliance publishes evidence-based guidelines for chronic diseases to help standardize health care across the state.79

Progressive lawmakers are also working on federal efforts to improve our understanding of which treatments and procedures work best, including the bipartisan congressional proposal that was included in the House reauthorization of SCHIP that would create a Center for Comparative Effectiveness within the existing federal Agency for Health Care Research and Quality.80 Sen. Obama’s plan calls for establishing an “independent institute to guide reviews and research on comparative effectiveness”81 to provide unbiased information to doctors and patients. To encourage providers to use that information in treating patients, Obama’s plan helps to “align incentives for excellence”82 by paying doctors for improved performance.

(Please see Appendix One for additional details regarding progressive leadership on expanding the availability of evidence-based standards for medicine).
Chronic illnesses—long-term conditions such as diabetes, hypertension, and heart disease—are one of the major cost-drivers in America’s health care system. People with chronic illnesses are the largest consumers of health care services, and rack up the vast majority of health care spending. Within the Medicare population, for example, the 63 percent of beneficiaries with two or more chronic conditions consume 95 percent of all Medicare expenditures. The economic and personal burden of chronic illness will only intensify, with some analysts estimating that half the population will have a chronic condition by 2030.

Overall, treating the 90 million Americans with chronic conditions costs our country about $1.2 trillion a year, or approximately two-thirds of national health care spending. Better care for individuals with these conditions can translate into substantial savings. If every diabetes patient received the appropriate primary care for their condition, for example, then national health care spending would fall by $2.5 billion.

Chronic illness is a particular problem for racial and ethnic minorities, and the poor. African Americans, for example, are more likely than any other ethnic group to die from chronic diseases such as cancer, cardiovascular disease, heart disease, and HIV/AIDS. Native Americans and Hispanics are more likely to die from diabetes. While disparities in health status and access to health care occur across a wide variety of measures, including mortality rates from acute illness, life expectancy and access to preventive care, these differences in the prevalence and impact of chronic illness have particularly dire implications for health care costs. Increasing rates of chronic illness within these groups of people, in combination with the growth of African Americans, Hispanics, and other disadvantaged groups within the overall population, strongly suggest that a national effort to reduce health disparities is a critical component of health care cost control.

Effective strategies for improving chronic illness care overall can also reduce disparities in care, improve the quality of care, and make spending more efficient. Improvements in dialysis and care for cardiovascular disease, for example, demonstrate that approaches that improve quality of care for all can have a particular impact on care for racial and ethnic minorities. At the same time, targeted strategies designed to reduce health disparities—among them addressing cultural and linguistic barriers to care, diversifying the health care workforce, improving access to preventive care, and improving data collection related to patients’ racial and ethnic characteristics—will also reduce the incidence and effect of chronic illness among these populations.
McCain’s position on disparities and chronic illness

While Sen. McCain proposes some approaches for addressing chronic illness—particularly by changing payment incentives to improve care coordination, and by dedicating federal research spending to curing chronic disease—he has yet to articulate any ideas for addressing health disparities, and fails to acknowledge the significant role health disparities play in health care costs.

Progressive leadership on health disparities

In contrast, both state and federal progressive policymakers are taking proactive steps to reduce disparities in health care. Several states are awarding grant dollars for research into chronic health disparities, and programs to help improve care for underserved groups. Other states are directing efforts to reduce disparities through state agencies, including the newly-created Pennsylvania Office of Health Equity. At the federal level, progressive lawmakers have introduced legislation to improve research and reporting on health disparities, including a 2007 bill to spend $500 million to ensure the collection and reporting of data, support research about health disparities, create an internet clearinghouse, and strengthen several existing agencies.

Reducing disparities in health plays a prominent role in Sen. Obama’s health reform plan. His plan takes a multipronged approach to the issue in seeking to improve access to regular care. He would improve care management through patient navigation programs that will help improve access to preventive and primary care, thus reducing the costs of chronic disease. He would diversify the health care workforce, which will help ensure more patients are receiving culturally appropriate care, and which should reduce the prevalence communication-related medical errors. And he would improve the measurement and reporting of the quality of care received by Americans—and specifically groups of people facing disparities in care—to help health care providers and others focus efforts to improve care for everyone.

(Please see Appendix Two for additional details regarding progressive leadership on addressing health disparities).
Health Information Technology: Improving the Information Flow

There are also investment costs to creating a new HIT system, but the benefits would outweigh those costs. Health care has not yet taken full advantage of the efficiencies and quality improvements that could be realized with the expanded use of information technology. Less than 25 percent of hospitals, and less than 20 percent of doctor’s offices, employ health information technology systems. Instead, the vast majority of health care providers continue to rely on paper records.

Health information technology, or HIT, promises to both reduce administrative waste and raise quality of care. Estimates vary, and real-life experience is limited, but one group of researchers finds that mean annual savings over a 15-year period would amount to $40 billion by improving health outcomes through care management, increasing efficiency, and reducing medical errors. Electronic prescriptions could possibly help prevent the more than 3 million adverse drug reactions Americans experience every year—and the 1.3 million medical visits they cause. Another study found that while the costs of widespread implementation of electronic medical records could cost $28 billion per year for the first 10 years (and $16 billion per year after that), the net savings are significant: between $21.6 and $77.8 billion per year.

The Congressional Budget Office offers a positive, if cautious, assessment of HIT: “Research indicates that in certain settings, health IT appears to make it easier to reduce health spending if other steps in the broader health care system are also taken to alter incentives to promote savings. By itself, the adoption of more health IT is generally not sufficient to produce significant cost savings.”

A perverse financial incentive—the disconnect between who must invest in implementing HIT systems and who will reap the benefit—explains why the market has failed to deliver the cost reductions and quality improvements information technology can bring to health care. Insurance companies, to a greater extent than providers, could benefit from reduced costs in moving from a paper-based system to electronic health records. Yet the costs of implementation are far higher for providers.

In addition, the widespread adoption of HIT is stymied by a lack of national standards. Many of the HIT products available on the market are not interoperable, keeping patients, providers, and insurers from fully realizing the benefits of HIT. Lack of national leadership in developing standards may have also kept some providers from investing in an HIT system out of fear that it may become obsolete or that it may be incompatible with a future national system.
McCain’s position on information technology

Sen. McCain sees the need for the “greater use of information technology to reduce costs,” but his plan includes no specific policy to address the barriers to widespread HIT implementation. He does not specify a mechanism for implementation, nor the amount and source of funds to make that cost and quality information widely available for consumers or physicians. Sen. McCain also calls for the “rapid deployment of 21st century information systems and technology that allows doctors to practice across state lines,” but he does not say how he will achieve that or what resources he will devote to achieving that goal.

His policy approach seems to be to rely on the free market. Yet the same market forces that have propelled the widespread adoption of information in other economic sectors have failed to produce the broad use of HIT today. Sen. McCain noted in his key address on health care: “Health information technology will flourish because the market will demand it,” but this faith in the free market has, to date, been unfulfilled. It is unclear how his policy will help reduce the administrative waste and medical error costs most closely associated with the lack of information technology in health care.

Progressive leadership on health information technology

Several progressive governors are leading the way in tackling two of the top barriers to the expansion of health information technology: funding and interoperability. Some states are working on developing statewide HIT networks. For example, Governor Ed Rendell (D-PA) established the Pennsylvania Health Information Exchange Governance Structure to develop and managed a statewide electronic health record system. Several other states have created tax credits or grants to help develop HIT, including $105 million in grants dispersed to 19 community-based organizations in New York to develop HIT.

Sen. Obama’s plan recognizes the market’s inability to deliver the expansions of HIT our health care system needs. He would dedicate $10 billion over the next five years to support the “broad adoption of standards-based electronic health information systems, including electronic health records, and will phase in requirements for full implementation of health IT.” This proposal is a concrete step toward developing a national HIT system.

(Please see Appendix Three for additional details regarding progressive leadership on expanding the availability of health information technology).
Prevention: Avoiding Cost by Minimizing Disease

The United States currently spends hundreds of billions of dollars every year treating diseases that could have been prevented or better managed. In 2002, for example, the direct and indirect cost of treating Americans with diabetes was approximately $132 billion. In comparison, just $70 billion went to the prevention of all diseases in 2002, which represents less than 5 percent of all American health care spending that year.

Insurance companies face a financial disincentive against covering preventive services. Because individuals frequently change their health insurance plans, insurers are unlikely to see the financial benefit of ensuring their policyholders receive preventive services. This may be why cholesterol screening is available through just 64 percent of insurers, and less than 20 percent of insurers cover services such as weight-loss counseling.

This can have tragic consequences for individuals with chronic diseases. For example, many insurers do not cover $150 preventive care sessions with podiatrists to help diabetics prevent related foot diseases. But most will cover a $30,000 foot amputation for that patient. In addition, this payment structure creates a financial incentive for doctors to focus on treating rather than preventing disease.

It can be difficult to quantify the possible savings from expanded prevention efforts, though there are specific savings examples. Experts estimate that just ensuring that every child receives every routine vaccination could reduce direct and indirect health care costs by up to $40 billion over time. In addition, if every senior was vaccinated for the flu, Medicare and the overall system would save $1 billion a year in costs.

Certainly, there is reason to believe that cost savings are possible through prevention, even after the upfront investment needed. Health prevention and promotion can also improve quality of life.

McCain’s position on prevention

Sen. McCain does discuss the need to expand the use of preventive care in the United States, but overall his plan is likely to actually decrease its use. His vision for health reform is to give control to consumers, which includes moving most Americans to the individual market where insurance policies are less likely to cover preventive services, and much more likely to require higher cost sharing through high deduct-
High deductibles, which shift the upfront costs of most basic care to individuals, have been found to deter individuals from seeking needed preventive care. And while he calls for preventative steps on smoking cessation, these efforts seem to be the realm of the private sector within this proposal.

Progressive leadership on prevention

Progressive federal lawmakers have provided leadership to fund disease prevention research, including for diabetes and arthritis. Progressive state governors have largely focused their efforts on expanding access by more directly funding preventive care.

Promoting prevention and public health is one of the three central tenets of Sen. Obama’s health reform plan. Under the plan, Obama will require federally funded health plans to cover preventive services such as cancer screenings and smoking cessation classes. And he calls for empowering employers and local communities in their efforts to implement workplace wellness programs and community-based preventive interventions.

(Please see Appendix Four for additional details regarding progressive leadership on expanding the availability of preventative services).
Creating Transparency on the Cost and Quality of Care

Our health care system suffers from a lack of information about the costs and quality of care Americans are receiving. Understanding the cost and the quality that health care providers are delivering is an important first step toward lowering costs and raising the quality of care. With this information, the government and major health care payers can reward high-quality providers, and low-quality providers have a greater incentive to improve. The effect of transparency needs to be further demonstrated, but some programs have already been shown to improve outcomes. Some providers were found to have improved their performance by simply reporting cost and quality measures.

McCain’s position on transparency

Sen. McCain talks about the importance of transparency, saying that “we must make public more information on treatment options and doctor records, and require transparency regarding medical outcomes, quality of care, costs and prices. We must also facilitate the development of national standards for measuring and recording treatments and outcomes.” But he seems more focused on voluntary reporting, which is no different than the system we have today, in which health insurers and providers could choose to report quality measures if they wanted to do so.

Progressive leadership on transparency

There have been several progressive bills in Congress sponsored by progressive leaders that promote transparency. The work that has been done, particularly on the state level, has focused on making quality information more available. More work remains to be done. For example, Sen. Obama introduced a bill in 2007 that would create federal Hospital Quality Report Cards. In addition, New Hampshire has established a “HealthCost” website for patients to use in comparing hospitals, and the Maine Health Management Coalition ranks physicians and hospitals.

Sen. Obama’s reform plan requires providers to report cost and quality information, and rewards providers who are high performers. His plan specifically targets preventable medical errors as one quality measure that must be reported, and for which provid-
ers can receive support to help prevent future occurrences. Obama’s plan also calls for using the federal government’s power as a major purchaser of health care to promote high-quality care by rewarding providers participating in public health programs and the Federal Employees Health Benefits Program who achieve certain quality outcomes.\textsuperscript{126}

(Please see Appendix Five for additional details regarding progressive leadership on expanding transparency).
Insurance for All Americans Is Fundamental for Containing Costs

The barriers to Sen. McCain finding cost-containment savings in health care is further limited because his plan does not ensure affordable health coverage for all Americans. He is very clear that he does not seek to cover all Americans, saying “the problem is not that most Americans lack adequate health insurance.” In contrast, progressives have provided leadership on trying to provide health care coverage for all through a mix of private- and public-sector programs.

The importance of affordable, continuous coverage for all

Broadly expanding coverage is “a precondition for effective measures to limit overall health care spending,” explains Brookings Institute economist Henry Aaron. The existing research suggests that the closer a health care system is to providing affordable coverage for all, the more successful it will be in achieving significant cost containment. This is because, as Aaron explains, the U.S. health care system relies on cross-subsidization to function. In a financing phenomenon some call “the hidden tax,” providers raise their fees for those with insurance in an effort to recoup lost dollars from the uninsured who cannot pay.

One study found such a cost-shift in California to represent about 10 percent of private premiums. If more people move to the low-premium approach of consumer-driven health care championed by Sen. McCain, then the ability for health care providers to cost-shift may be reduced. As a result, even more people could lose access to health care as it becomes more and more costly, eventually driving up costs in the long run.

McCain’s plan leaves tens of millions uninsured and underinsured, thereby weakening cost containment

Sen. McCain’s plan undermines his stated intent to contain costs because it doesn’t even attempt to cover all Americans. In fact, his plan undermines cost containment by:

- **Allowing individuals and families to cycle on and off coverage, increasing costs.** To be fully effective, disease management and prevention must be an ongoing, continuous effort. Sen. McCain’s plan could increase the already high number of Americans who do not have a steady source of insurance, meaning that the full potential of some preventive policies to contain costs may be constrained or even
reversed. Further, an individual’s health status can fall after being uninsured for just a short period of time, which could well happen under Sen. McCain’s plan. If all children were fully vaccinated, the U.S. health system would save up to $40 billion in direct and societal costs over time. In one study, the management of diabetes over time reduced costs by $1,000 per patient per year, as well as improving health for patients.

- **Further fragmenting health care delivery and weakening coordination of care.** The U.S. health care system is already highly fragmented—both on a system level and a provider level. Multiple private insurers and public payers—including state Medicaid programs, state employee coverage, worker’s compensation benefits, the Medicare program, and military health care—maintain different coverage rules and payment requirements. The system’s complexity is also reflected at the service delivery level, where many patients receive care from multiple providers who have little interaction. This is especially true for the elderly and those with chronic conditions.

This fragmentation and complexity bears significant responsibility for the explosion of health care costs. The consulting firm McKinsey & Co. concludes that the United States pays an “excessive” $500 billion a year in health spending—excessive meaning health spending that is not accounted for by the country’s comparative prosperity. This excess spending pervades the U.S. health care system, and can be attributed in part to the administrative complexity of a system that relies on multiple health insurance companies and other payers.

Sen. McCain’s approach could exacerbate this fragmentation because individuals and families may be given an incentive to change doctors based on who is offering the cheapest services on a given day. Instead of creating continuity through a set of health care providers, individuals could see a larger number of different doctors. This could also be difficult in maintaining the health status of children, who are especially vulnerable to disruptions in the continuity of care.

- **Discouraging access to care, including the use of preventive care and disease management.** Consumer-driven care requires individuals to pay for the “first-dollar” of care, therefore creating an incentive to forgo needed or preventive care, and potentially driving up long-term costs. In some cases, cost sharing can help drive more efficient spending, as in the case of encouraging the use of generic drugs over brand name drugs. But the high deductible is indiscriminate in discouraging individuals from seeking necessary or unnecessary care. Harvard Business School professor Regina Herzlinger raises doubts about the success of high-deductible plans, saying that they, “are being touted as a way to control costs, and I very much doubt that claim.”

In fact, a recent survey shows that those in high deductible health plans are more likely to forgo needed medical care and medications due to cost, as compared to those in traditional health plans. Surveys also show that those with high deductible plans were much more likely to not fill prescriptions or to skip a prescribed dose.
Research shows that an even higher percentage of low-income people in so-consumer-driven health plans will forgo needed care in the face of higher costs.\textsuperscript{141} For adults with incomes under $50,000, about half delayed or avoided care—a rate almost twice for the same income group enrolled in traditional insurance.\textsuperscript{142}

While preventative and chronic care can sometimes be excluded from the deductible, many times they are not. It is these plans that have the potential to drive up costs in the future because individuals may avoid purchasing care that could prevent higher future costs. In fact, for children, the danger is significant as the benefits of preventative care are well-established.\textsuperscript{143}

**Progressives maximize cost savings by advancing health coverage for all**

In contrast to Sen. McCain, progressive health advocates understand that extending affordable health coverage to all Americans is a key step in controlling health care costs—with Sen. Obama having made clear statements of his intent to cover all Americans.\textsuperscript{144} The extension of health care to all will help fully leverage health care savings, with a recent Commonwealth Fund study finding that, “policies aimed at achieving savings while also improving quality would be even more effective in improving overall health system performance if they were combined with a policy to extend affordable health insurance coverage to everyone in the United States.”\textsuperscript{145}

It is possible to achieve simultaneously savings, efficiency, and universal coverage. Indeed, it could be the case that the most effective means of moving forward is to take simultaneously steps.\textsuperscript{146} While approaches differ, common elements among progressive to expand coverage include: ensuring that all low-income Americans can enroll in the Medicaid and SCHIP programs; establishing mechanisms for obtaining affordable private insurance coverage; providing income-related financial help for health insurance premiums; and establishing new purchasing options, financial assistance, or both for small businesses. These efforts recognize the key problems facing uninsured Americans today—the high cost of health coverage, and the limited range of coverage options.
Conclusion

There is little evidence in support of Sen. McCain’s claim that his plan could successfully contain health costs. On the contrary, the evidence shows that his plan’s reliance on conservative ideology may increase health costs in some areas. His plan to expand the individual market could put consumers at an even greater disadvantage than the current system, and could increase administrative costs.

Since Sen. McCain’s plan lacks a mechanism to ensure all Americans have access to affordable health coverage, his ability to contain costs is reduced even further. He acknowledges the need to address certain areas, such as evidence-based medicine, prevention, and transparency, but he fails to articulate concrete steps on how to be successful.

In contrast, progressive reform plans are well-suited to achieving cost containment. Progressive governors are already implementing some of these reforms, and congressional leaders have put forth a range of proposals to contain U.S. health care costs. Sen. Obama’s plan dedicates up-front resources designed to help make our health care system more rational and efficient in the long run. Building on the leadership shown generally by the progressive leaders around the country, his plan is a serious step toward achieving positive change.
Appendix One:
Promoting Effective Care

Progressive leaders have developed new thinking about how to improve the effectiveness of health care. In fact, much of the recent state and congressional efforts to expand evidence-based medicine come from progressive policymakers.

While not intended to be an exhaustive list, some progressive-led efforts include:

- **North Carolina promotes quality, evidence-based care.** In April of 2008, North Carolina Democratic Governor Mike Easley created the North Carolina Quality Health Care Alliance. The purpose of the alliance is to standardize health care across the state. The organization has created evidence-based guidelines for five different chronic conditions. It has a two-year budget of $8 million.¹⁴⁷

- **Pennsylvania combats chronic disease with evidence-based medicine.** Pennsylvania Democratic Governor Ed Rendell signed an executive order in May 2007 establishing the Governor’s Chronic Care Management, Reimbursement, and Cost Reduction Commission. The commission is required to ensure that health care providers use evidence-based medicine.¹⁴⁸

- **Maine’s Quality Forum.** This organization was created as a part of Democratic Governor John Baldacci’s comprehensive health reform plan for Maine, Dirigo Health. One of the Quality Forum’s “key tasks” is to “promote use of best medical practices” through collecting research on evidence-based medicine, and encouraging its use among providers.¹⁴⁹ Two years ago, the “In a Heartbeat” project launched to release evidence-based practices for the treatment of heart attacks.

- **Oregon leads research on drugs.** Begun under the leadership of Governor John Kitzhaber, Oregon led a joint effort with partner states to launch the Drug Effectiveness Review Project. The program, “conducts systematic evidence-based reviews” of various pharmaceutical programs, primarily on behalf of various state Medicaid programs.¹⁵⁰

- **Dingell proposes legislation that includes comparative effectiveness research.** In 2007, Rep. John Dingell (D-MI) introduced H.R. 3162, The Children’s Health and Medicare Act of 2007. The legislation would establish a Center for Comparative Effectiveness in the Agency for Health Care Research and Quality. The center would be responsible for conducting research about the outcomes, effectiveness, and appropriateness of health care treatments.¹⁵¹
Appendix Two: Addressing Disparities in Chronic Disease

Progressive leaders have a long history of seeking to reduce the disparities in access to quality care for disadvantaged populations. Recent efforts have included providing resources for tracking disparities in health care, and programs that work to eliminate them at the state and federal level, in contrast to conservative inaction.

While not intended to be an exhaustive list, some progressive-led efforts on health disparities include:

- **Massachusetts awards health disparities grants.** Massachusetts’ Governor Deval Patrick’s administration awarded $1 million in grants in November 2007. The grants will support programs that are working to improve delivery, diversify the workforce, and provide resources at the community level.\(^{152}\)

- **Pennsylvania creates Office of Health Equity.** Pennsylvania Governor Ed Rendell signed an executive order in May 2007 creating the Office of Health Equity, and the Office of Health Equity Advisory Committee. The office is responsible for raising awareness about disparities, and working to promote policies and programs that eliminate disparities.\(^{153}\)

- **Colorado establishes health disparities grant program.** Colorado Governor Ed Ritter signed a law in May 2007 that created a health disparities grant program. The program provides funding for research and development focused on prevention and treatment of diseases prevalent in minority populations, such as cancer, diabetes, and pulmonary disease.\(^{154}\)

- **Washington creates health disparities council.** Washington State Governor Christine Gregoire created the Governor’s Interagency Council on Health Disparities in 2006. The council was a consequence of a Washington State Legislature Bill sponsored by a group of Democratic State Senators. The council must create an action plan for eliminating disparities by 2012. It must also work toward reducing language barriers in the health care system.\(^{155}\)

- **New Jersey mandates cultural competency training.** New Jersey Democratic Governor Richard Codey signed legislation in 2005 that mandated cultural competency training for all physicians in the state. New Jersey was the first state to require such a mandate.\(^{156}\)
• **Minority Health Equity Act introduced by Rep. Solis in House.** In 2007, Rep. Hilda Solis (D-CA) introduced the Health Equity and Accountability Act. The bill would require federal agencies to increase data collection and reporting about health disparities.\(^\text{157}\)

• **Kennedy/Jackson health disparity legislation.** Sen. Ted Kennedy (D-MA) introduced the Minority Health Improvement and Health Disparity Elimination Act in 2007. Representative Jesse Jackson (D-IL) introduced the bill on the House side. The bill would spend $500 million to ensure the collection and reporting of data, to support research about health disparities, to create an Internet clearinghouse, and to strengthen several existing agencies.\(^\text{158}\)

• Medicare Improvements for Patients and Providers Act of 2008. The just-passed Medicare bill, H.R. 6331, lead through a Democratic Congress by Rep. Charles Rangel (D-NY), includes disparities provisions - requires the Secretary to “evaluate approaches” to collect data that would permit identification of disparities, racial, gender, or ethnic, in health care services and performance. The Secretary would be required to submit a report on possible approaches to the Congress within 18 months of enactment, and to implement one of the strategies within 24 months. The data would be collected in concert with the Department’s existing quality improvement reporting activities.\(^\text{159}\) This bill is also discussed in Appendix Five.
Appendix Three: Health Information Technology

Although the bulk of efforts to expand health information technology have come from progressive governors and lawmakers, some Republican governors (in Minnesota, Louisiana, and California) have committed resources to moving HIT policy forward. However, Sen. McCain’s position stands in contrast to these key Republican leaders working to provide resources and leadership on this issue.

While not intended to be an exhaustive list, some progressive-led efforts on health information technology include:

- **Pennsylvania creates health data exchange.** In 2008, Pennsylvania Democratic Governor Ed Rendell signed an executive order establishing the Pennsylvania Health Information Exchange Governance Structure. The goal of PHIX is to develop and manage a statewide system for storing and sharing electronic health records.

- **New York supports health IT.** New York Governor David Paterson announced in 2008 that his state awarded $105 million in grants for the development of health information technology. The grants were given to 19 community-based organizations, and range from $1 million to $10 million each.

- **Arizona promotes e-prescribing.** Arizona Governor Janet Napolitano signed an executive order in May 2008 directing state agencies to work with the Arizona E-Health Connection to promote the expansion of e-prescribing.

- **Wisconsin provides tax credits for the adoption of HIT.** In 2007, Wisconsin Governor Jim Doyle signed into law the state budget, which contained one provision providing tax credits for health care providers who purchase HIT tools, and $10 million has been allocated for that purpose.

- **Delaware becomes first state to build statewide health information network.** In April 2006, the Delaware Health Information Network announced that they would be the first state to sign a contract to begin the actual creation of a statewide health information exchange network. The DHIN was created in 1997 under the leadership of Governor Thomas Carper. Carper went on as a senator to secure $5 million for DHIN from Congress, with the help of Sen. Joe Biden (D-DE) and Rep. Mike Castle (R-DE).
- **Wired for Health Care Quality Act.** Introduced in 2007 by Sen. Edward Kennedy, this bill would create the Office of the National Coordinator of Health Information Technology to “develop a strategic plan for implementing a nationwide interoperable health information technology infrastructure.” This new office would focus on how HIT could help improve quality, address prevention and disease management needs, and alleviate health disparities. The bill has 15 cosponsors, including Sen. Obama. This bill is also discussed in Appendix Five.

- **Dingell introduces health IT bill.** Rep. John Dingell (D-MI), sponsor of the Protecting Records, Optimizing Treatment, and Easing Communication through Health Care Technology Act of 2008, introduced the bill on June 24, 2008. The legislation would require the development of a plan for universal adoption of electronic health records by 2014, and provides financial incentives, among other things. It has bipartisan co-sponsors and is scheduled for a full committee markup later this year.
Appendix Four: Prevention

Many progressive reform proposals address financial incentives to encourage insurers to cover prevention services, as well as encouraging individuals to use those services. In contrast, moderate Republican Governor Arnold Schwarzenegger of California is one of only a few Republicans to offer a proposal to fund prevention services, particularly around obesity. \(^\text{170}\)

While not intended to be an exhaustive list, some progressive-led efforts on prevention:

- **New York State issues grants for childhood obesity prevention.** In 2007, the State of New York issued $4 million in grants to establish three Centers for Best Practices to Prevent and Reduce Childhood Obesity. The grants were a part of former Governor Eliot Spitzer’s comprehensive initiative to combat childhood obesity in New York. \(^\text{171}\)

- **Tennessee grants money for diabetes prevention and treatment.** Project Diabetes, an initiative created by Tennessee Governor Phil Bredesen in 2006, recently announced that they have funded $2.6 million in grants for the prevention and treatment of diabetes across the state. \(^\text{172}\)

- **Delaware pays for cancer screening tests.** The Delaware Screening for Life uses a combination of state and federal funds to pay for breast, cervical, and colorectal cancer screening for eligible individuals. A media campaign targets both the general population and African Americans specifically. \(^\text{173}\)

- **Democrats introduce Diabetes Prevention Access and Care Act.** Rep. Diana DeGette (D-CO) and Sen. Frank Lautenberg (D-NJ) introduced a bill in 2007 that would require the director of the National Institute of Health to support greater research, and support programs to prevent and treat diabetes, especially in minority populations. \(^\text{174}\)

- **Democrats introduce arthritis prevention legislation.** Sen. Ted Kennedy (D-MA) and Rep. Anna Eshoo (D-CA) introduced legislation in both the Senate and the House that would require additional research and programs about arthritis and other rheumatic diseases. The Arthritis Prevention, Control, and Cure Act of 2007 would also require a study on the economic impact of such diseases. \(^\text{175}\)
Appendix Five: Transparency

Progressives have worked hard to increase transparency. There have been conservative and bipartisan efforts, such as bills by Representative Michael Burgess (R-TX), and Senator Judd Gregg (R-NH), but progressives continue to lead.

While not intended to be an exhaustive list, some progressive-lead efforts on transparency include:

- **New Hampshire HealthCost website.** In 2007, the state’s Departments of Insurance and Health rolled out an online tool allowing consumers to compare the costs of care at medical facilities statewide, shepherded to completion by Democratic Governor John Lynch and the Democratic Legislature.

- **Maine’s Quality Forum.** The Maine Health Management Coalition ranks physicians and hospitals and makes the information publicly available. The Safety Star program is designed to publicly identify Maine hospitals that exceed set safety standards.

- **Voluntary Medicare Quality Reporting Act of 2007.** Sen. Benjamin L. Cardin (D-MD) introduced S. 1519, and Representative Bart Gordon (D-TN) introduced a matching bill, H.R. 2749. The legislation would require the Secretary of the Department of Health and Human Services to evaluate quality reporting mechanisms currently in place before transitioning to a voluntary quality reporting system. Sen. Whitehouse, (D-RI) has put forth important bills on this topic as well.

- **Wired for Health Care Quality Act.** Sen. Ted Kennedy (D-MA) introduced S. 1693. Among other provisions, this bill would require the Secretary of Health and Human Services to designate a single organization that would be responsible for the development of quality measures and provide recommendations to the Secretary on the key priorities for a national system of performance measurement. This legislation also permits the Agency for Healthcare Research and Quality to award grants to organizations to support the development and testing of quality measures. This bill is also discussed in Appendix Three.

- **Medicare Improvements for Patients and Providers Act of 2008.** The just-passed Medicare bill, H.R. 6331, lead through a Democratic Congress by Rep. Charles Rangel (D-NY), has a number of pro-transparency provisions, including designating the National Quality Forum as the entity responsible for prioritizing and endorsing national quality measures (with $10 million federal funding), requiring private fee-for-service health plans in Medicare to report quality measures, and taking other important steps. This bill is also discussed in Appendix Two.

- **Hospital Quality Report Card Act.** Sen. Barack Obama (D-IL) introduced S. 1824 on July 19, 2007. The bill requires the Secretary of HHS to establish a Hospital Quality Report Card Initiative to evaluate health care quality in hospitals. It also authorizes the establishment of the Hospital Quality Advisory Committee.
Endnotes


2 Ibid.


8 Based on author’s calculations using data from the Current Population Survey’s “Historical Health Insurance Tables”


38 McCain’s original health plan stated that he would, “Protect the health care consumer through vigorous enforcement of federal protections against collusion, unfair business actions, and deceptive consumer practices.” However, following the most recent health plan announcement in April 2008, this statement was taken off the McCain website and the new plan makes no mention at all of consumer protection.


52 Peter Harbage, “McCain’s Hidden Increase in Health Costs,” Center for American Progress, May 2008
53 CBO estimates that administrative costs range from 9 percent for firms with > 100 workers to 27 percent for two-employee businesses. Using 2006 Census data on the distribution of covered workers by firm size and assuming firms with less than 100 have administrative costs at the midpoint of the CBO range, the average for administrative costs for employer-based coverage is 12 percent.
54 Congressional Budget Office, CBO’s Health Insurance Simulation Model (Washington, DC: CBO, October 2007).
55 Peter Harbage, “McCain’s Hidden Increase in Health Costs,” Center for American Progress, May 2008
63 B. Grow and R. Berner, “Fresh Pain for the Uninsured: As doctors and hospitals turn to GE, Citi, and smaller rivals to finance patient care, the sick pay much more,” Business Week, December 3, 2007.
65 Other plans of note include those by 2008 Democratic presidential candidates Sen. Hillary Clinton and former Sen. John Edwards.
71 Ibid.
77 John McCain, “Straight Talk on Health System Reform.” Available at http://www.johnmccain.com/InformingIssues/19ba2f1c-c03f-4ac2-8cd5-5cf2ed527cf.htm
78 http://www.johnmccain.com/InformingNews/Speeches/2c3fa3a-748e-4121-84db-28995cf367da.htm>
81 Barack Obama, “Plan for a Healthy America.” Available at www.barackobama.com/issues/health care/#lower-costs.
82 Ibid.


87 The Partnership to Fight Chronic Disease, www.fightchronicdisease.org.


102 John McCain, “Straight Talk on Health System Reform.” Available at http://www.johnmccain.com/Informing/Issues/19ba2f1c-c03f-4ac2-8cd5-5cf2edb527cf.htm

103 John McCain, “Straight Talk on Health System Reform.” Available at http://www.johnmccain.com/Informing/Issues/19ba2f1c-c03f-4ac2-8cd5-5cf2edb527cf.htm


126 Barack Obama. “Plan for a Healthy America.” Available at www.barackobama.com/issues/health care/coverage-for-all.


130 Len M. Nichols and Peter Harbage, “Estimating the Hidden Tax on Insured Californians due to the Care Needed and Received by the Uninsured,” New America Foundation, May 2007; Ken Thorpe, Paying a Premium: The Added Cost of Care for the Uninsured, FamiliesUSA, June 2005.

131 Families USA on 80 million uninsured every two years


GovTrack.us. “H.R. 6357—110th Congress (2008): To amend the Public Health Service Act to promote the adoption of health information technology, and for other purposes,” http://www.govtrack.us/congress/bill.xpd?bill=h110-6357

NGA Center for Best Practices, “California Proposes Increased Physical Education in Schools,” February 23, 2006, http://www.nga.org/portal/site/nga/menuitem.9123e83a1f6786440ddcbeeb501010a0/?vgnextoid=e897e4e678399010vgnVCM1000001a0010a0aRCRD&vgnextchannel=4b18f0740d9ff00VgnVCM1000001a0010a0RCRD


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