Health Care in the 2012 Presidential Election

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How the Obama and Romney Plans Stack Up

Sara R. Collins, Stuart Guterman, Rachel Nuzum,
Mark A. Zezza, Tracy Garber, and Jennie Smith

October 2012

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Health Care in the 2012 Presidential Election

How the Obama and Romney Plans Stack Up

Sara R. Collins, Stuart Guterman, Rachel Nuzum,
Mark A. Zezza, Tracy Garber, and Jennie Smith

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Abstract: With President Obama and Governor Romney offering fundamentally different visions for the nation's health system, this fall's presidential election provides a stark choice for U.S. voters. To inform public discussion about health care in the election and beyond, this analysis draws from microsimulation analysis to contrast the potential impact of implementing the Affordable Care Act in full with Romney's proposals to repeal the law, eliminate many of the new requirements for insurance markets, and make changes in Medicaid and Medicare. The report focuses on the following: the number of Americans expected to gain health insurance; changes in the affordability of insurance; changes in consumer protections and consumer choice; help for small businesses; improvement in Medicare solvency; improvement in health care quality; and control of health spending growth. Findings of the analysis indicate that, in each area, implementation of the Affordable Care Act would likely outperform Romney's proposals.

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EXECUTIVE SUMMARY

With the U.S. presidential election just five weeks away, health care is in the spotlight. President Obama and Governor Romney have proposed distinctly different approaches to the health care problems currently plaguing the United States: more than 48 million people without health insurance, increases in health care costs and premiums that exceed the growth in family incomes, and uneven quality in health care across the country. If reelected, the president has pledged to continue to implement the Affordable Care Act, the health reform law whose major provisions to expand insurance coverage and improve health care delivery will be rolled out in the next 15 months. In contrast, the Republican nominee has said that, if elected, he will work to repeal the law and replace it with his own vision for U.S. health care.

To inform public discussion about health care in the presidential election and beyond, this report describes the candidates' approach, examines key differences in how each would address the current problems affecting the health care system, and evaluates the potential implications of their respective plans on health insurance coverage and out-of-pocket spending. The comparison relies on results of microsimulation analysis of the candidates' plans conducted by economist Jonathan Gruber.

THE CANDIDATES' APPROACHES TO SOLVING THE NATION'S HEALTH CARE PROBLEMS

With each candidate offering fundamentally different visions for the nation's health care system, this fall's presidential election provides a stark choice for U.S. voters (Exhibit ES-1). In pledging to fully implement the Affordable Care Act, President Obama supports the goal of near-universal health insurance coverage, by maintaining existing private insurance markets but also instituting tighter and more standardized regulations across the country to ensure a broad choice of comprehensive health plans to all who seek coverage. In addition, federal tax credits would make individually purchased health plans more affordable. The Medicaid program would cover more families with low or moderate incomes.

Governor Romney, on the other hand, has not identified universal coverage as a goal. While also supporting a health insurance system based on existing markets, he believes that more limited regulation will ensure a broad choice of health plans for consumers. Romney would encourage more people to buy health plans in the individual market by making the tax treatment of individually purchased coverage similar to that now accorded to employer-based plans. By reducing federal funding to Medicaid, through a proposed system of state block grants, and loosening federal requirements, his administration would substantially scale back the federal–state public insurance program for people with low incomes.

Exhibit ES-1. Comparison of the Affordable Care Act and Governor Romney's Plan: Goals and Provisions

	Affordable Care Act	Romney
Aims to cover all Americans	X	
State health insurance exchanges	X	
Tax credits or tax advantages for private insurance premiums	X	X
Expanded eligibility for Medicaid	X	
Consumer insurance protections	X	X
New Medicare benefits	X	
Individual requirement to have health insurance	X	
Cost containment	X	X
Incentives for quality improvement	X	X

Sources: Commonwealth Fund Health Reform Resource Center, available at http://www.commonwealthfund.org/Health-Reform/Health-Reform-Resource.aspx; and Governor Mitt Romney's plan, available at http://www.mittromney.com/.

To contain growth in health care costs and improve the quality of care, Obama supports the health law's reforms targeting both how insurance markets operate and how providers are paid and care is delivered. Romney would seek to drive down health care costs by providing fixed budgets and looser standards to state Medicaid programs, on the theory that doing so will allow states to innovate and save money. On Medicare, Romney would introduce competition between private plans and traditional Medicare by providing beneficiaries with "premium support" to buy the plan they choose. He would also place limits on annual spending, starting in 2023, if such competition fails to bring down costs.

COMPARING THE CANDIDATES' PLANS FOR HEALTH CARE

To examine how the Obama and Romney health plans stack up, this analysis asks seven key questions:

- Will the plans increase the number of Americans with health insurance?
- Will the plans make health insurance more affordable?
- Will the plans protect consumers?
- Will the plans improve consumer choice?
- Will the plans help small businesses?
- Will the plans improve Medicare?
- Will the plans improve health care quality and slow health care spending growth?

Will the candidates' plans increase the number of Americans with health insurance?

Methods. To evaluate the effects of the candidates' proposals for health insurance coverage, Jonathan Gruber, an economist at the Massachusetts Institute of Technology, modeled three policy scenarios:

1. The baseline, or what insurance coverage would be if the Affordable Care Act had not been implemented.
2. The Affordable Care Act fully implemented, with all states participating in the Medicaid expansion.
3. Romney's proposals to:
   – Provide federal block grants to states for their Medicaid programs
   – Provide the same tax advantages to people who buy coverage on their own as those available to people insured through an employer.

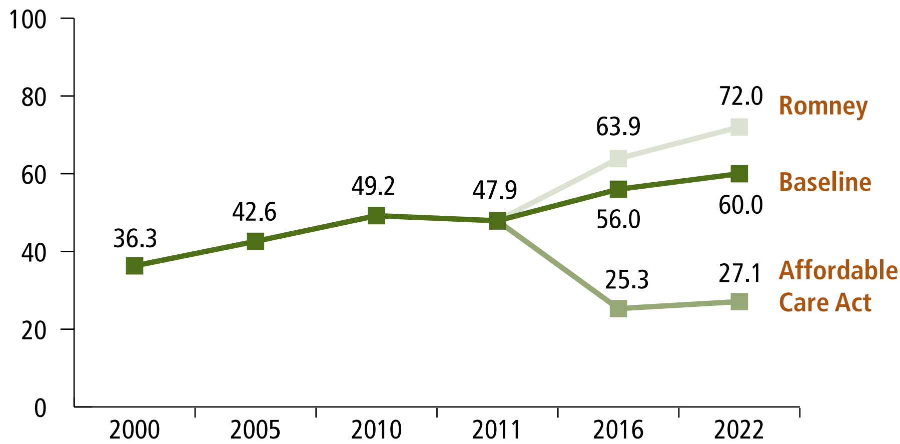
Because the Romney campaign has not yet fleshed out the details of these two proposals, this report makes a set of assumptions for each to assess their potential effects. For the Medicaid block grant proposal, the following assumptions are made:

- Block grants to states will grow at the rate of growth in the consumer price index plus 1 percent.
- States will match this lower federal rate of spending growth in their share of Medicaid spending.
- States will meet these new limits through a 50–50 combination of cuts in Medicaid costs, such as lower payments to health care providers or reduced benefits, and through reduced eligibility for the program.
- States will maintain existing Medicaid eligibility for the elderly and people with disabilities, so that any eligibility cuts needed to meet spending targets will come from the reduced eligibility of people who are under age 65 and not disabled.

To evaluate the Romney proposal to give tax advantages to individually purchased plans, a scenario was modeled in which people who purchased health insurance in the individual market could deduct premiums from their income on an "above-the-line" basis—that is, a deduction available to all, not just those who itemize their taxes.

Results. When fully implemented, the Affordable Care Act is projected to substantially reduce the number and share of adults and children who are uninsured in every state, in every income group, and in every age group. In the absence of the Affordable Care Act—the baseline scenario mentioned above—60 million people are projected to be uninsured by 2022. The health reform law will reduce the number of uninsured people by an estimated 32.9 million, leaving 27.1 million people uninsured (Exhibit ES-2).

Exhibit ES-2. Numbers of Uninsured Under the Affordable Care Act and Governor Romney's Plan



Note: Baseline scenario is if the Affordable Care Act had not been enacted in 2010; Affordable Care Act is full implementation of the law; Romney plan includes full repeal of the Affordable Care Act and replacement with state block grants for the Medicaid program and equalization of the tax treatment of individually purchased health plans and employer plans.
Sources: *Income, Poverty, and Health Insurance Coverage in the United States: 2011*, U.S. Census Bureau, Sept. 2012; estimates by Jonathan Gruber and Sean Sall of MIT using the Gruber Microsimulation Model for The Commonwealth Fund.

In contrast, the analysis projects that Romney's proposals will increase the number and share of people who are uninsured in every state and demographic group, even compared with the baseline scenario. Nationally, Romney's proposals are estimated to increase the number of uninsured people by 12 million compared with the baseline (no Affordable Care Act), leaving 72 million people uninsured in 2022. More than 80 percent of the increase in the uninsured population (10.3 million people) stems from cuts in Medicaid eligibility resulting from state block grants. An estimated 1.9 million people would lose coverage under an income tax deduction for individually purchased coverage, since some employers may stop offering health insurance if their employees have an alternative. A similar dynamic is expected to occur as a result of the insurance provisions of the Affordable Care Act.

People with incomes below 250 percent of the federal poverty level ($27,925 for individuals and $57,625 for a family of four) would be particularly hard hit by Romney's proposals to repeal the Affordable Care Act and replace it with Medicaid block grants and private insurance incentives. While the health reform law's substantial expansion of Medicaid is projected to decrease the uninsured rate among people with incomes under 138 percent of the poverty level ($15,415 for an individual and $31,809 for a family of four) from a projected 38.6 percent to 19.4 percent, or 34.2 million uninsured people to 17.2 million, Romney's proposals are projected to *increase* the uninsured rate in this income range to 43.7 percent, or 38.7 million people. (Exhibit ES-3). Similarly, while the subsidized private plans that will be available under the law through the new state insurance exchanges are projected to decrease the share of uninsured people with moderate incomes (up to $57,625 for a family of four) from 28.3 percent to 6.9 percent, or 13.8 million uninsured people to 3.3 million, the Romney plan would raise the uninsured rate in this income range to 36.4 percent, or 17.7 million people.

Depending on how states respond to Medicaid block grants, coverage of children might be particularly affected under Romney's proposals. With expanded eligibility for Medicaid and income-based subsidies available for private coverage purchased through the exchanges, the percentage of uninsured children falls from 12.1 percent to 7.2 percent under the Affordable Care Act, or from an estimated 10 million uninsured children to 6 million. In contrast, Romney's proposals to repeal the health reform law and replace it with

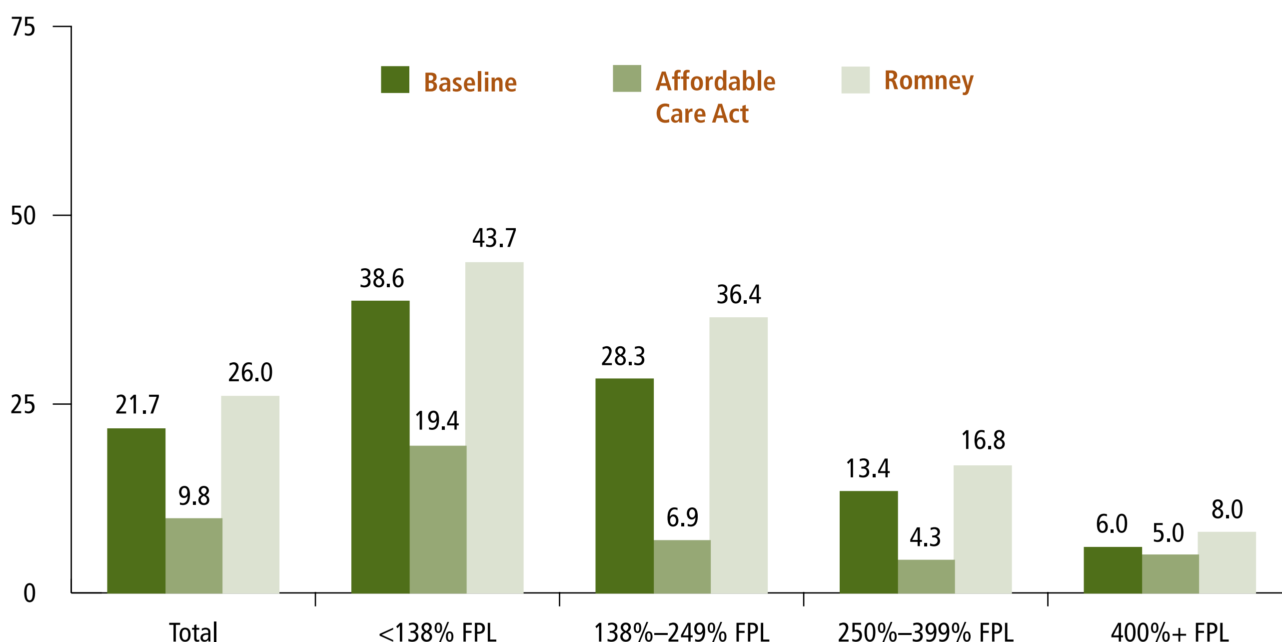
Medicaid block grants and tax incentives to purchase individual market plans *increase* the percentage of uninsured children, from 12.1 percent to 21.6 percent, or 10 million uninsured children to 17.9 million.

Larger numbers of young adults and baby boomers also are estimated to be without coverage under Romney's proposals than under the Affordable Care Act. Provisions of the reform law have especially targeted young adults, including the current ability of young adults to maintain health coverage on parent's policy until the age of 26. Consequently, the number of uninsured young adults is estimated to decline from 17.4 million, or 38.8 percent of 19-to-29-year-olds, to 7.2 million, or 16 percent of this age group in 2022. Romney's proposals are estimated to increase the number of uninsured young adults, to 18.6 million, or 41.4 percent. Among older adults ages 50 to 64, 4.9 million are estimated to be uninsured under the Affordable Care Act, compared with 11.8 million under the combination of Romney's proposals.

Across the country, in every state, the percentage of people under age 65 who are uninsured declines under the Affordable Care Act and increases under Romney's proposals, relative to the baseline. Uninsured rates are estimated to decline to 10 percent ot 15 percent in 12 states and the District of Columbia, and to less than 10 percent in the rest of the states. People living in the South and West are projected to make particularly dramatic gains under the reform law (Exhibit ES-4). For example, uninsured rates in 11 states are estimated to fall by more than 15 percentage points from projected levels (in Alaska, Arkansas, Florida, Georgia, Idaho, Louisiana Mississippi, Montana, New Mexico, South Carolina, and Texas).

Romney's plan to repeal the Affordable Care Act and replace it with block grants to states for Medicaid and new tax incentives for health plans purchased in the individual market are expected, on balance, to reduce health insurance coverage in every state (Exhibit ES-5). Under the assumption

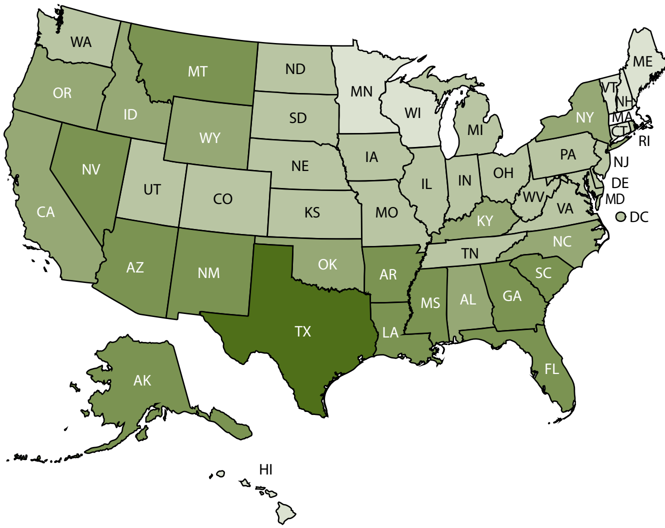
Exhibit ES-3. Percent of Population Uninsured Under the Affordable Care Act and Governor Romney's Plan Compared with Baseline by Poverty, 2022



Note: Baseline scenario is if the Affordable Care Act had not been enacted in 2010; Affordable Care Act is full implementation of the law; Romney plan includes full repeal of the Affordable Care Act and replacement with state block grants for the Medicaid program and equalization of the tax treatment of individually purchased health plans and employer plans. FPL refers to federal poverty level.
Source: Estimates by Jonathan Gruber and Sean Sall of MIT using the Gruber Microsimulation Model for The Commonwealth Fund.

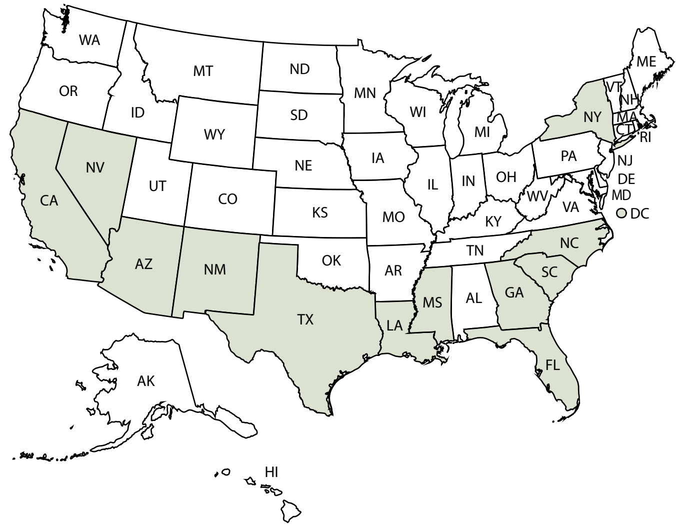
Exhibit ES-4. Uninsured Nonelderly Under Baseline and the Affordable Care Act in 2022, by State

Baseline



22% of nonelderly uninsured

Affordable Care Act

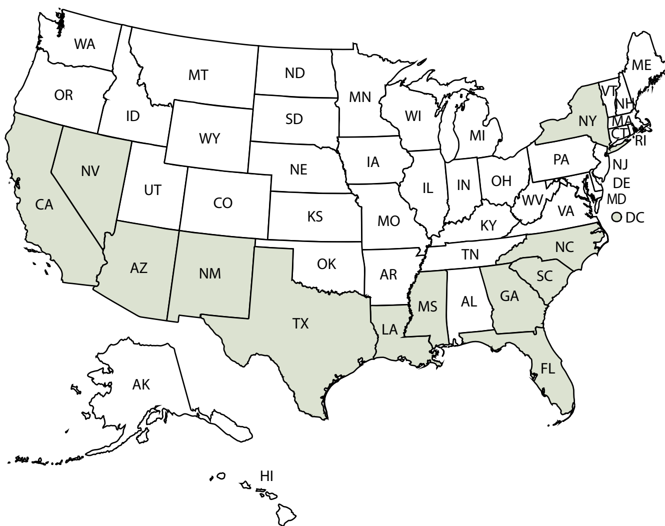


10% of nonelderly uninsured

Note: Baseline scenario is if the Affordable Care Act had not been enacted in 2010; Affordable Care Act is full implementation of the law; Romney plan includes full repeal of the Affordable Care Act and replacement with state block grants for the Medicaid program and equalization of the tax treatment of individually purchased health plans and employer plans.
Source: Estimates by Jonathan Gruber and Sean Sall of MIT using the Gruber Microsimulation Model for The Commonwealth Fund.

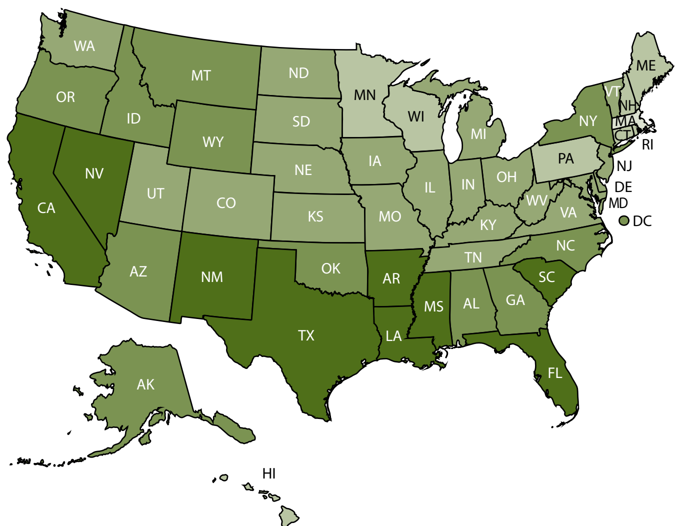
Exhibit ES-5. Uninsured Nonelderly Under the Affordable Care Act and Governor Romney's Plan in 2022, by State

Affordable Care Act



10% of nonelderly uninsured

Romney



26% of nonelderly uninsured

Note: Baseline scenario is if the Affordable Care Act had not been enacted in 2010; Affordable Care Act is full implementation of the law; Romney plan includes full repeal of the Affordable Care Act and replacement with state block grants for the Medicaid program and equalization of the tax treatment of individually purchased health plans and employer plans.
Source: Estimates by Jonathan Gruber and Sean Sall of MIT using the Gruber Microsimulation Model for The Commonwealth Fund.

that states respond to reduced federal financing for Medicaid by a 50–50 combination of lowering per capita spending in the program, through changes in provider reimbursement or benefits or other efficiencies, and reducing eligibility, 30 percent or more of the under-65 population in nine states, mostly in the South and West, are projected to be uninsured by 2022. In an additional 12 states, 25 percent to 30 percent of the under-65 population may be uninsured by that year. Thus, in 21 states, a quarter or more of the under-65 population might be without health insurance in 2022 if Romney's proposals become law.

Will the candidates' plans make health insurance more affordable?

Health insurance premium tax credits under the Affordable Care Act provide a greater subsidy for twice the number of people compared with Governor Romney's proposal to repeal the law and instead equalize the tax treatment of employer-based coverage and plans purchased in the individual insurance market. Under the Affordable Care Act, by 2016 about 20 million people are projected to be eligible for tax credits to help pay the cost of health plans sold through the insurance exchanges. The beneficiaries of the credits are expected to be evenly split between people who had been uninsured until that point and people who had insurance. The average per-person tax credit is estimated to range from $3,900 to $4,500.

The Romney plan to repeal the health reform law and equalize the tax treatment of employer and individually purchased plans, as described above, would benefit about half the number of people—10 million—with the primary beneficiaries being those who already have health insurance. An estimated 1 million people who were previously uninsured would take the deduction. The average value of the tax deduction, ranging from $1,900 to $2,600, is also lower than the value of the reform law's tax credits.

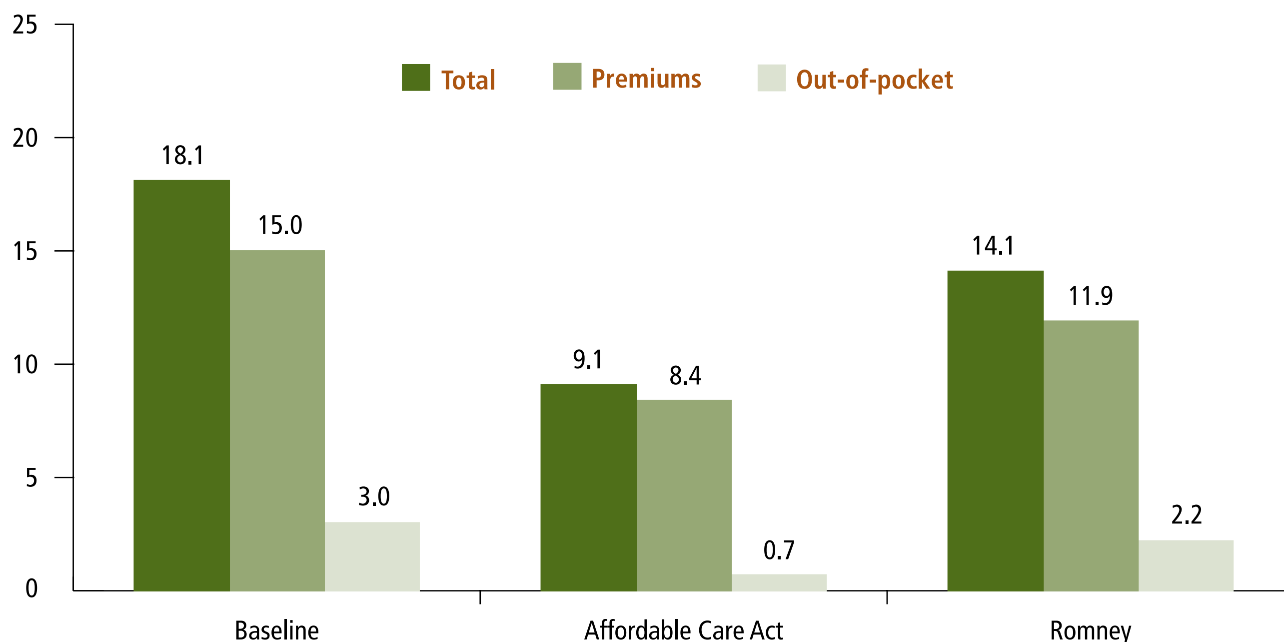
People who currently do not have health coverage through an employer and must purchase a plan on their own are projected to spend less of their income on health care under the Affordable Care Act than they would if the law were repealed and replaced with Medicaid block grants and new tax incentives to purchase individual coverage. Without the Affordable Care Act in place—the baseline scenario—people buying coverage in the individual market are estimated to spend, on average, 18.1 percent of their income on coverage in 2016, including 15 percent on health insurance premiums and 3 percent on out-of-pocket costs (Exhibit ES-6). With the health reform law in place, the combination of premium tax credits, limits on out-of-pocket spending, and consumer protections reduces costs for people purchasing coverage through the new insurance exchanges or the individual market to 9.1 percent of income, on average, including 8.4 percent of income on premiums and 0.7 percent on out-of-pocket costs. Under Romney's proposals, people buying coverage on their own are projected to spend 14.1 percent of their income on premiums (11.9%) and out-of-pocket costs (2.2%).

Will the candidates' plans protect consumers?

To protect consumers and improve the functioning of individual and small-group insurance markets, the Affordable Care Act initiated a set of sweeping reforms whose rollout began in 2010 and will continue through 2014. Almost all states have taken legislative or regulatory steps to implement the law's "Patient's Bill of Rights," which went into effect in 2010 and includes a ban on the insurance company practice of rescinding, or terminating, a health insurance policy (for example, as a result of new diagnosis of illness), a ban on restrictions of lifetime or annual benefits, a ban on excluding children with a preexisting condition from enrollment, and the requirement to cover preventive care services without cost-sharing. Beginning in 2014, insurers will no longer be able to deny or restrict coverage based on preexisting health conditions, and they will be prohibited from charging higher premiums based on health status or gender.

Governor Romney's proposal to repeal the law would remove these protections. In their place, Romney has said that he would prevent discrimination against people with preexisting conditions who maintain continuous coverage. The federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) currently achieves this by preventing both group and individual market health plans from excluding coverage

Exhibit ES-6. Average Percent of Income Spent on Health Care in the Nongroup Market Under the Affordable Care Act and Governor Romney's Plan Compared with Baseline, 2016



Note: Baseline scenario is if the Affordable Care Act had not been enacted in 2010; Affordable Care Act is full implementation of the law; Romney plan includes full repeal of the Affordable Care Act and replacement with state block grants for the Medicaid program and equalization of the tax treatment of individually purchased health plans and employer plans.
Source: Estimates by Jonathan Gruber and Sean Sall of MIT using the Gruber Microsimulation Model for The Commonwealth Fund.

of preexisting conditions for people who have been insured continuously.

Will the candidates' plans improve consumer choice?

Besides cost and underwriting, the most significant challenges that consumers face if they must buy health coverage on their own is a lack of information about the plans that are available to them. Benefits can vary widely from plan to plan, and cost-sharing responsibilities and limits on coverage can be difficult to assess at the point of purchase. President Obama seeks to address this information gap through the Affordable Care Act's state insurance exchanges, which will provide a menu of health plan choices that include information on premiums and cost-sharing, benefits covered, participating providers, and ratings of plan quality and enrollee satisfaction. All plans offered through the exchanges and individual and small-group markets will include a standard package of "essential benefits" sold at four different "tiers": bronze, silver, gold, and platinum. Plans offered within each tier will cover the same share of someone's medical costs on average, ranging from 60 percent in the bronze tier to 90 percent in the platinum tier. In this regard, the health reform law should help those consumers who lack access to the guidance in making plan choices that is typically provided by employers that offer health benefits.

A Romney presidency would seek to repeal these consumer-oriented provisions, and replace them with a new set of proposals, including encouraging *Consumer Reports*–type ratings for health plans and allowing consumers to purchase health insurance across state lines. Under the latter proposal, insurance carriers would be free to choose a state in which to be licensed and then sell coverage in other states, without having to comply with the regulations in each state. The nonpartisan Congressional Budget Office (CBO) has estimated that such a policy would lead to fewer consumer protections across all states, higher premiums for enrollees in poor health, and lower premiums for people in better health. An estimated 600,000 people would gain health insurance and about 200,000 would

lose it. Romney would also allow people to pay insurance premiums with pretax contributions to health savings accounts—medical savings instruments that are coupled with high-deductible health plans. Currently people can use these accounts only to pay out-of-pocket expenses tax-free.

Will the candidates' plans help small businesses?

Just as it provides new options for consumers who must buy coverage on their own, the Affordable Care Act also offers remedies to the challenges faced by small businesses that want to offer health insurance to their employees. Health insurance carriers will no longer be able to deny coverage or charge small businesses higher premiums on the basis of the health of their workforce. Small low-wage firms with fewer than 25 workers are now eligible for tax credits to offset their premium costs; 170,000 small employers claimed tax credits worth $468 million for the 2010 tax year. The Obama administration has proposed increasing the size of firms that are eligible to 50 employees. New state exchanges for small businesses (the so-called SHOP exchanges) will enable employers to offer a menu of plan choices to their workers. In addition, the exchanges will likely handle the collection and payment of premiums on behalf of employers and insurance carriers, reducing administrative costs for small businesses.

Governor Romney's proposal to repeal the reform law would increase costs for employers that are currently taking advantage of the premium tax credits. It would also mean that small employers in some states would continue to be denied coverage and charged higher premiums based on the health of their workforces. Romney has proposed empowering small businesses to form purchasing pools—also known as multiple employer welfare arrangements (MEWAs) and association health plans—but has not laid out a specific policy proposal. MEWAs, which exist in most states, allow small employers to band together through trade and other associations to share the administrative costs of providing health insurance, and they are often able to avoid state insurance market regulations and benefit requirements. This has the potential to lower premiums for employers with younger and healthier workers but raise them for employers with older workforces, who may continue to purchase coverage in the small-group market. MEWAs have allowed many small employers to offer their workers coverage more cheaply, but some have been plagued by insolvency problems.

Will the candidates' plans improve Medicare?

The Affordable Care Act began enhancing Medicare benefits in 2010, when the infamous "doughnut hole" in prescription drug coverage began to be phased out and preventive care services and an annual wellness visit became available to beneficiaries without cost-sharing. The law also includes provisions to reduce spending, increase revenues, and improve the quality of care. On net, the Trustees of the Medicare Trust Fund estimate that these changes will extend the solvency of the Medicare Hospital Insurance (Part A) Trust Fund, which pays for hospital and other services used by Medicare beneficiaries, to 2024. Without the law, the trust fund would be depleted by 2016.

Governor Romney's intent to repeal the law would restore the doughnut hole in Medicare's prescription drug benefit and reinstate cost-sharing for preventive care services and annual wellness visits. According to CBO estimates, repeal would also end the Medicare spending reductions and higher taxes and fees in the law, increasing net Medicare spending by $716 billion over the period 2013 to 2022. This higher Medicare spending would also deplete the Trust Fund more quickly—by 2016, rather than 2024.

The Romney campaign proposes a new way to reduce costs in the Medicare program: providing beneficiaries with a lump sum to pay for premiums and allowing them to apply the amount to either a Medicare private plan or traditional Medicare. In addition, the age of eligibility would increase gradually to 67 by 2034. As chairman of the House budget committee, Rep. Paul Ryan, Romney's running mate, has proposed similar changes to Medicare, although he would retain the Medicare provisions in the Affordable Care Act. In Ryan's most recent proposal, individuals who become eligible for Medicare beginning in 2023 would be allotted a "premium support" subsidy, adjusted for health status and income, to use for either a private plan or traditional Medicare. If competition between plans failed to rein in cost growth sufficiently, starting in 2023

the per capita cost of the program would be limited to the rate of growth in the nation's gross domestic product, or GDP, plus 0.5 percentage points. CBO has estimated that by 2050, federal spending for new enrollees under Ryan's proposal would be 35 percent lower than under current law.

Romney, however, has pledged to repeal those Medicare provisions in the law that CBO estimates would decrease average federal spending on Medicare, including the reforms contained in Ryan's earlier proposal. Under the Romney–Ryan approach, this means that pressure to lower Medicare spending would be greater, and beneficiaries would likely face higher out-of-pocket spending, if the level of premium support failed to keep pace with growth in health care costs.

Will the candidates' plans improve health care quality and slow health care spending growth?

The Affordable Care Act includes an extensive set of new demonstration programs and incentives aimed at improving the quality and lowering the cost of health care. These include payment innovations, like higher reimbursement for preventive care services and patient-centered primary care; bundling payments for hospital, physician, and other services provided for a single episode of patient care; enabling accountable provider groups that assume responsibility for the continuum of a patient's care to share in the savings they generate; and pay-for-performance incentives for Medicare providers.

In July, CBO estimated that a House Republican bill to repeal the Affordable Care Act would result in a $109 billion increase in the federal budget deficit over 2013–2022 (Exhibit ES-7). Governor Romney's proposals to replace the law with Medicaid block grants and premium support for Medicare beneficiaries would reduce federal spending on the two programs. This approach to cost containment would shift the burden of growth in U.S. health care costs from the federal government to the states, to low-income families, and to Medicare beneficiaries, without addressing the underlying causes of rising costs.

To slow health care cost growth, the Romney campaign has also proposed reforms that would facilitate health information technology interoperability, promote alternatives to fee-for-service payment of physicians, cap noneconomic damages in medical malpractice lawsuits, and provide innovation grants to explore nonlitigation alternatives to dispute resolution. Romney's proposed repeal of the Affordable Care Act would eliminate many of the incentives to promote the full use of health IT and develop alternative provider payment mechanisms. A CBO analysis of capping noneconomic damages in

Exhibit ES-7. Estimated Budgetary Effects of Repealing the Affordable Care Act, 2013–2022

	July 2012 Congressional Budget Office estimate
Net change from coverage provisions	**–$1,171**
Coverage provisions	–$1,677
Revenues and wage effects	$506
Net change from payment and system reforms	**$711**
Reductions in annual updates to Medicare provider payment rates	$415
Medicare Advantage reform	$156
Provider payment changes and other provisions	$140
Net change in noncoverage revenues	**$569**
Manufacturer and insurer fees	–$165
New Medicare taxes on high-income earners	–$318
Other provisions	–$87
Total net impact on federal deficit, 2013–2022	**$109**

Notes: Totals do not reflect net impact on deficit because of rounding.
Source: D. Elmendorf, "Letter to the Honorable John Boehner" (Washington, D.C.: Congressional Budget Office, July 24, 2012).

medical malpractice lawsuits found that such limits could lower malpractice insurance premiums and provide some small savings in health care costs, about 0.5 percent or less of total health spending.

CONCLUSION

On each of the seven criteria used in this analysis to evaluate the candidates' health care platforms, President Obama's plan to fully implement the Affordable Care Act would likely outperform Governor Romney's plan to repeal the law and replace it with fewer federal requirements for insurance markets and reduced funding for the Medicaid and Medicare programs. This conclusion is driven in part by the considerable detail available in the health reform law and the new guidance and regulations issued by the Department of Health and Human Services to implement its provisions, compared with Romney's far less detailed proposals to replace the law.

The Affordable Care Act both substantially increases and improves health insurance coverage in private insurance markets and in public insurance programs for Americans across income and age groups, while also providing new incentives aimed at improving health care quality and lowering the rate of growth in spending. Fully two-and-a-half years after its passage, with many of its provisions already in place, the law is already interwoven into the nation's regulatory and industrial landscape. In 15 months, the major insurance coverage provisions are set to roll out, with more than 30 million people projected to gain subsidized coverage over the next decade.

Of course, raising our health system's level of performance to achieve sustainable, near-universal access to affordable health insurance and health care, improved quality and patient-centeredness, greater accountability for both health outcomes and treatment costs, and better overall population health will require much more than the efforts of the federal government. Regardless of the outcome of the election, it will be critical for state and federal policymakers, regulators, businesses, consumers, and other key stakeholders to work together to achieve the vision of high-quality, safe health care at a price that everyone in America can afford.

INTRODUCTION

With the 2012 presidential election just five weeks away, health care is in the spotlight. President Obama and Governor Romney have proposed distinctly different approaches to the health care problems currently plaguing the United States: more than 48 million people without health insurance, growth in health care costs and premiums that exceeds that of family incomes, and uneven quality in health care across the country. If reelected, the president has pledged to continue to implement the Affordable Care Act, the health reform law whose major provisions to expand insurance coverage and improve health care delivery will be rolled out in the next 15 months. In contrast, his challenger has said that, if elected, he would work to repeal the law and replace it with his own vision for U.S. health care.

To inform public discussion about health care in the presidential election and beyond, this report describes both candidates' approaches, examines key differences in how each would address the current problems affecting the health care system, and evaluates the potential implications their respective plans will have for health insurance coverage and out-of-pocket spending. The comparison relies on results of microsimulation analysis of the candidates' plans conducted by economist Jonathan Gruber (for more on Gruber's simulation model, see methodology, page 52).

THE CANDIDATES' PLANS FOR HEALTH CARE

President Obama and Governor Romney have put forth distinctly different approaches to reining in the steady growth in both the number of people lacking adequate health insurance and national spending on health care. The candidates' proposals are described below, followed by a comparison of the two plans.

President Barack Obama

Overall approach: Full implementation of Affordable Care Act, including new subsidized health insurance options, consumer insurance protections, cost containment and health system improvement incentives, improved Medicare benefits.

Special focus: State flexibility, subject to federal requirements; affordability of health coverage; patient-centered care; providers working in teams to coordinate care; consumer choice.

New insurance coverage options: In 2014, near-universal health insurance coverage achieved through Affordable Care Act's substantial expansion in eligibility for Medicaid and premium tax credits, which will cap premium contributions as a share of income for people purchasing private health plans through new state insurance exchanges.

Consumer protections: "Patient's Bill of Rights" went into effect in 2010; bans insurance carriers from retroactively canceling health coverage and from placing lifetime or annual limits on benefits; requires plans to cover preventive services without cost-sharing; and bans exclusion of children from coverage because of a preexisting health condition. Beginning in 2014, insurers will be prevented from denying or limiting coverage based on preexisting conditions and charging higher premiums based on health status. All plans sold through exchanges and in individual and small-group markets will be required to include new essential health benefit package similar to those offered in employer-based health plans.

Consumer choice: People with coverage through employers will be able to keep it as long as it is offered to them. People without coverage through a job, as well as small businesses, will be able to choose plans from menu provided by new state insurance exchanges, with information available on plan premiums and cost-sharing, benefits covered, participating providers, plan quality, and enrollee satisfaction. Plans sold at four different "tiers": bronze, silver, gold, and platinum. Plans within each tier cover same average share of medical costs, from 60 percent in bronze tier to 90 percent in platinum tier.

Small businesses: Small businesses with fewer than 25 employees and average wages of under $50,000 eligible for premium tax credits covering 35 percent of cost of contributions to employee premiums; President Obama proposed increasing eligibility to businesses with up to 50 workers. Starting in 2014 and continuing through 2016, tax credits increase to 50

percent of employer premium contributions for plans purchased on small business exchanges (set up through Small Business Health Options Program, or SHOP), which will be available in each state. Small businesses with 50 to 100 workers can offer choice of plans through exchange or buy coverage in small-group market outside exchange. Exchanges will aggregate employer and employee premium contributions across plans and pay insurance carriers directly.

Individual requirement to have health insurance: Beginning in 2014, everyone will be required to indicate on tax return if they have health insurance meeting minimal standards; some will have to pay penalty if they do not have insurance. Penalty is equal to greater of $95 or 1 percent of taxable income in 2014, $325 or 2 percent of taxable income in 2015, and $695 or 2.5 percent of taxable income in 2016. Dollar amount of penalty capped at $2,085 per family; no one would pay more in penalties than national average premium for bronze plan to be sold through the exchanges. No one will be prosecuted for not having health insurance. Exemptions to penalty include: individuals who cannot find plan costing less than 8 percent of their income; people with low incomes (below $9,750 for individual, $19,500 for married couple); people who have been uninsured for under three months; certain other circumstances.

Employer shared responsibility requirement: Large employers (50 or more full-time workers) not offering health insurance will make $2,000 payment per full-time employee if employee becomes eligible for premium tax credit through exchange. Each company's first 30 full-time workers are not considered in penalty calculation. Among large firms offering coverage: if full-time worker is eligible for tax credit through exchange, either because premium contribution exceeds 9.5 percent of income or coverage does not meet minimum standards (plan covers less than 60 percent of enrollee's costs), company must pay lesser of $3,000 for each full-time worker who receives such premium subsidy through exchange or $2,000 for each full-time worker, with first 30 workers excluded.

Medicare beneficiaries: Affordable Care Act phases out "doughnut hole" in prescription drug coverage for Medicare beneficiaries over decade. In 2010, Medicare beneficiaries whose drug spending reached doughnut hole automatically received $250 rebates. In 2011, those who reached doughnut hole received 50 percent discount on brand-name drugs. Additional discounts on brand-name and generic drugs to be phased in to close doughnut hole completely by 2020. Law provides Medicare beneficiaries preventive care services without cost-sharing and annual wellness visit with no copayment. Law extends life of Medicare Trust Fund to 2024 through reductions in payment increases for hospitals and other nonphysician provider services and tax increases on higher-income earners.

Cost containment and quality improvement: Law provides new incentives to providers to develop innovations in health delivery to lower costs and improve quality. New Center for Medicare and Medicaid Innovation (CMMI) is developing new ways of paying providers and caring for patients enrolled in Medicare, Medicaid, and Children's Health Insurance Program (CHIP). Patient-Centered Outcomes Research Institute (PCORI) encourages research on treatments and patient outcomes. Medicare Value-Based Purchasing program links portion of hospital payments to quality of care provided. Payments temporarily increased for primary care doctors for Medicare and Medicaid patients. Medicare Shared Savings program rewards groups of providers forming accountable care organizations (ACOs) who agree to take joint responsibility for care of patients they treat and be accountable for quality, outcomes, and costs of care.

Number of uninsured covered in 2022 compared with baseline (no Affordable Care Act): 32.9 million.

Remaining uninsured in 2022: 27.1 million.

Governor Mitt Romney

Overall approach: Repeal the Affordable Care Act and replace with block grants for Medicaid, tax advantages for individually purchased health insurance, high-risk pools, sale of insurance across state lines, malpractice reform, premium support for Medicare beneficiaries.

Special focus: State flexibility, with reduced federal requirements; federal government helping markets work; free markets and fair competition; consumer choice.

New insurance coverage options: Reduced federal funding and looser state requirements for Medicaid. States can design their own approaches to covering uninsured, such as exchanges, subsidies, high-risk pools, reinsurance; extending tax advantages to people who buy coverage in individual market; allowing consumers to purchase health insurance in any state regardless of residence; letting people with health savings accounts use them to pay premiums.

Consumer protections: Limits on federal standards and requirements for both private insurance and Medicaid coverage; permitting people with preexisting conditions to maintain their health insurance as long as they are insured continuously.

Consumer choice: Encourage *Consumer Reports*–type ratings of insurance plans.

Small businesses: Empower small businesses to form purchasing pools.

Medicare beneficiaries: People becoming eligible for Medicare beginning in 2023 would be given a choice of private plans competing with traditional Medicare. Beneficiaries receive premium support subsidy, adjusted for health and income, to apply to cost of private plan or traditional Medicare. If competition between plans fails to constrain costs, growth in per capita Medicare costs would be limited to nominal growth in gross domestic product (GDP) plus 0.5 percent.

Cost containment and quality improvement: In Medicare program, competition between health plans with premium support for beneficiaries and annual limits on spending growth by 2023. Replace federal Medicaid matching payments to states with block grants that would rise by fixed rate each year, equal to the rate of growth in the consumer price index plus 1 percent. Cap noneconomic damages in medical malpractice lawsuits; facilitate health information technology interoperability; offer innovation grants to explore nonlitigation alternatives to dispute resolution; promote alternatives to fee-for-service payment of physicians.

Number of uninsured covered in 2022 compared with baseline (no Affordable Care Act): –12 million.

Remaining uninsured in 2022: 72 million.

COMPARING THE CANDIDATES' PLANS FOR HEALTH CARE

To examine how the candidates' health plans stack up, this analysis asks the following questions:

- Will the plans increase the number of Americans with health insurance?
- Will the plans make health insurance more affordable?
- Will the plans protect consumers?
- Will the plans improve consumer choice?
- Will the plans help small businesses?
- Will the plans improve Medicare?
- Will the plans improve health care quality and slow health care spending growth?

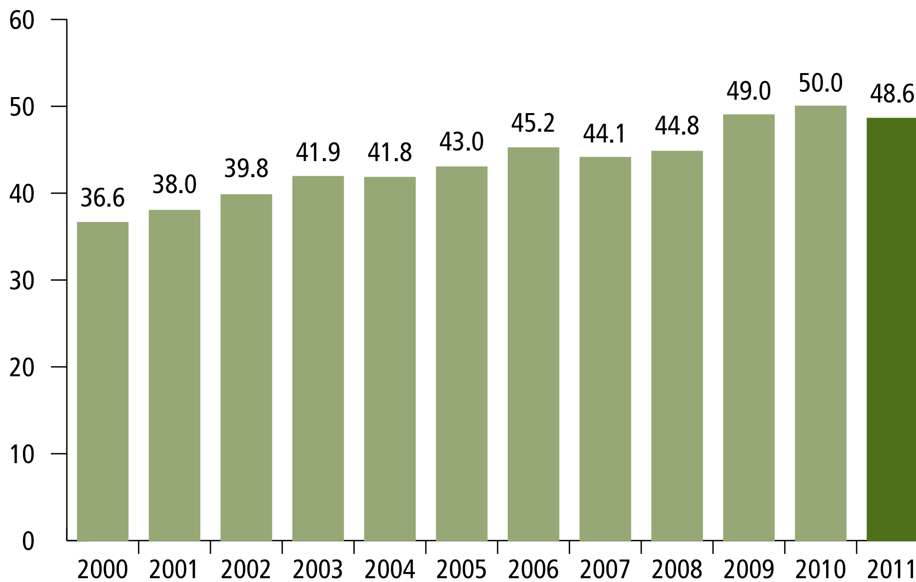
1. Will the Candidates' Plans Increase the Number of Americans with Health Insurance?

The Problem

The number of people without health insurance in the United States climbed steadily over the last decade, rising from 36.6 million in 2000 to 50 million in 2010 (Exhibit 1). In 2011, however, the number fell by 1.3 million, likely driven by increases in the number of insured young adults, as a result of the Affordable Care Act's provision allowing those under age 26 to enroll in their parents' health plans.[1] Rising health care costs and sluggish income growth have made health insurance less protective for millions of Americans. A recent study found that deductibles for employer-based plans doubled over the period 2003 to 2010.[2] In 2010, an estimated 29 million insured adults under age 65 had such high out-of-pocket costs relative to income that they could be considered underinsured, an increase from 16 million people in 2003.[3] Both these trends have had serious financial and health consequences for U.S. families. An estimated 73 million adults, both with and without health insurance, reported problems paying their medical bills in 2010 and 75 million reported a time that they did not get needed health care because of the cost.[4]

Exhibit 1. The Number of Uninsured Fell by 1.3 Million People in 2011

Millions of uninsured, full U.S. population



Source: *Income, Poverty, and Health Insurance Coverage in the United States: 2011,* U.S. Census Bureau, Sept. 2012.

Exhibit 2. Premium Tax Credits and Cost-Sharing Protections Under the Affordable Care Act

Federal poverty level	Income	Premium contribution as a share of income	Out-of-pocket limits	Percent of medical costs covered on average: silver plan
100%–137%	S: $11,170 – <$15,415 F: $23,050 – <$31,809	2% (or Medicaid)	S: $1,983 F: $3,967	94%
138%–149%	S: $15,415 – <$16,755 F: $31,809 – <$34,575	3.0%–4.0%		94%
150%–199%	S: $16,755 – <$22,340 F: $34,575 – <$46,100	4.0%–6.3%		87%
200%–249%	S: $22,340 – <$27,925 F: $46,100 – <$57,625	6.3%–8.05%	S: $2,975 F: $5,950	73%
250%–299%	S: $27,925 – <$33,510 F: $57,625 – <$69,150	8.05%–9.5%		70%
300%–399%	S: $33,510 – <$44,680 F: $69,150 – <$92,200	9.5%	S: $3,967 F: $7,933	70%
400%+	S: $44,680+ F: $92,200+	—	S: $5,950 F: $11,900	—

All plans cover essential health benefit package at four levels of cost-sharing:
- 1st tier (bronze) actuarial value: 60%
- 2nd tier (silver) actuarial value: 70%
- 3rd tier (gold) actuarial value: 80%
- 4th tier (platinum) actuarial value: 90%

Catastrophic policy with essential benefits package available to young adults and people whose premiums are 8%+ of income

Notes: Premium and cost-sharing credits are for silver plan. Federal poverty levels are for 2012.
Source: Commonwealth Fund Health Reform Resource Center: What's in the Affordable Care Act? (PL 111-148 and 111-152), http://www.commonwealthfund.org/Health-Reform/Health-Reform-Resource.aspx.

The Candidates' Solutions

President Obama: The Affordable Care Act

If reelected, President Obama would continue to implement the Affordable Care Act, which is designed to provide health insurance to nearly all legal U.S. residents. This is to be accomplished primarily through new subsidized private health plans that will be available through a new insurance marketplace, or exchange, in each state, and a substantial expansion in eligibility for the Medicaid program (see box below); both of these changes will go into effect 15 months from now, in January 2014. People with incomes below 138 percent of poverty ($15,415 for an individual and $31,809 for a family of four) will be eligible for Medicaid (Exhibit 2). Those earning up to 400 percent of poverty ($44,680 for a single person and $92,200 for a family of four) will be eligible for premium tax credits, which will cap their premium contributions at anywhere from 2 percent to 9.5 percent, based on family income. In addition, new insurance regulations will protect consumers against being denied coverage or from being charged a higher premium on the basis of health or gender. Limits are also placed on the degree to which premiums can increase with age.

Starting in 2010, the law also provided people who have been particularly at risk for being uninsured, including young adults and people with chronic health problems, with a bridge to the 2014 reforms. Consequently, an estimated 6.6 million young adults, including 3.1 million who were previously uninsured, stayed on or enrolled in their parents' health plans over 2010–2011; prior to the law's passage, these individuals would not have been eligible for such coverage.[5] In addition, 78,000 people with health problems who previously were not able to obtain coverage in the individual insurance market because of their health enrolled in preexisting condition insurance plans made available in each state.[6]

The Affordable Care Act's Expansion in Eligibility for Medicaid

The Affordable Care Act created the largest expansion in eligibility for Medicaid since the program's inception in 1965 by covering all legal U.S. residents with incomes up to 138 percent of the federal poverty level ($15,415 for an individual and $31,809 for a family of four), beginning in 2014.[7] Prior to the expansion, only people with low incomes who fell into certain categories (children, parents, pregnant women, people with disabilities, and those over age 65) were eligible for Medicaid. The law sets a new eligibility floor that will include adults without children. By 2022, an estimated 18 million more people under age 65 will be enrolled in Medicaid, reducing the uninsured rate for this income range from 38.6 percent to 19.4 percent.

To help states finance their Medicaid expansions, the federal government will cover 100 percent of the costs for most states through 2016, before gradually reducing its contribution to 90 percent for all states by 2020. This exceeds current federal matching rates for states' existing Medicaid programs (which range from 50% to 74%) and the Children's Health Insurance Program (CHIP) (65% to 82%). This new financing translates into an infusion of federal dollars into states to the tune of $668 billion over the period 2014–2020. In addition, with millions of people currently without insurance covered, states could save $90 billion or more between 2014 and 2019 through reduced uncompensated care and care for people with mental illness, according to Urban Institute estimates.[8]

The Supreme Court ruling in June 2012 allows states to choose whether to participate in the expansion, and some states have expressed reservations about joining.[9] But if history is a guide, it is likely that most states will expand their programs over time. Medicaid was launched in 1966, and by 1972 most states were participating; Arizona was the last state to join, in 1982.[10] CHIP began in 1997, and by 1999 all 50 states were participating. Indeed, many states have used federal waivers to expand their eligibility thresholds in both programs and make improvements in benefits: about 60 percent of current state Medicaid spending is not federally required.[11]

Governor Romney

If elected, Governor Romney has pledged to repeal the health reform law. In its place, he proposes to encourage states to design their own approaches to help people who are uninsured, whether through new insurance exchanges, subsidies, or high-risk pools. He says he would enable states to do this by capping the federal share of Medicaid funding for states and distributing it in the form of block grants (see box below).[12] Under the present system, the federal government provides funding to states as a share of their expenditures, which allows funding to rise with costs and the level of enrollment. Under Romney's proposal, block grants would grow at a rate independent of Medicaid enrollment or per-enrollee health costs. Romney would also loosen federal requirements for the program, which he says would enable states to design ways to cover more uninsured people, despite the lower rate of federal funding.

At the federal level, Romney proposes a number of changes intended to increase the appeal of health plans purchased in the individual market. Currently, both employers and employees enjoy tax advantages from offering and being enrolled in employer-based health plans—advantages that do not extend to people who must buy health insurance on their own. Romney proposes to end such "tax discrimination" against the purchase of individual market insurance, though he has yet to explain how he would accomplish this.

Romney also proposes to allow consumers to purchase health insurance in any state, regardless of where they live. States currently regulate their individual insurance markets very differently. In addition, he would expand the use of tax-preferred health savings accounts (HSAs), which allow people who have high-deductible health plans to receive pretax contributions from their employers or deduct their own contributions from their taxable income. These accounts may then be drawn down to pay for uncovered medical care tax-free. Romney would allow people to pay their premiums from HSAs as well tax-free.

Block-Granting the Medicaid Program

Governor Romney has proposed converting the federal matching funds provided to states for their Medicaid programs into block grants with fixed dollar amounts. The block grants would grow at the rate of growth in the consumer price index plus 1 percent.

As chairman of the House budget committee, Representative Paul Ryan, Romney's running mate, included similar proposals in his budget proposals of the past two years. Ryan, like Romney, would also repeal the Affordable Care Act provisions to increase coverage—premium tax credits and an expansion in eligibility for Medicaid. The Congressional Budget Office estimates that these changes would reduce spending on Medicaid, the Children's Health Insurance Program (CHIP), and the premium tax credits by 76 percent by 2050, with most of the reductions coming from the Medicaid program.[13] John Holahan and colleagues estimate that under Ryan's 2011 budget proposal, states would experience a reduction in spending over the 2012–2021 period ranging from 25.7 percent in Washington to 44.4 percent in Wyoming.[14]

Romney and Ryan have not yet specified what state responsibilities would remain for Medicaid under their proposals. There is also uncertainty about how states would respond to lower federal spending: Would they find efficiencies, increase spending, or cut their programs? But Holahan et al. point out that growth in per-enrollee Medicaid spending is already lower than that of overall growth in U.S. health spending and in premiums for employer-based health insurance, placing limits on the degree to which states could lower per-enrollee costs to meet their lower budgets. In addition to new efficiencies, states would have to either spend more on their programs and/or cut back their programs through a combination of reduced eligibility, lower provider payments, reduced benefits, or higher cost-sharing by beneficiaries. This would likely result in both a loss of coverage and reduced access to care, particularly during economic downturns, when federal funds have helped states finance increased need for their programs.

How the Candidates' Solutions Stack Up on the Number of Insured

Analytic Assumptions

To evaluate the effects of the candidates' proposals for health insurance coverage, Jonathan Gruber of the Massachusetts Institute of Technology modeled three policy scenarios:

1. ***The baseline.*** This is what insurance coverage would be if the Affordable Care Act had not been implemented.
2. ***The Affordable Care Act fully implemented.*** Although the Supreme Court decision allows states to choose whether they want to participate in the law's Medicaid expansion, this analysis assumes that, by 2022, all states will have elected to participate, given the substantial federal matching for the expansion—100 percent of the costs in most states through 2016, phasing down to 90 percent for all states by 2020.
3. ***Governor Romney's proposals to:*** 1) provide federal block grants to states for their Medicaid programs; and 2) confer the same tax advantages to people who buy coverage on their own as those who get insurance through an employer.

Because Romney has not yet fleshed out the details of his two proposals, this analysis relies on a set of assumptions for each to assess the potential impact. For the Medicaid block grant proposal, the following assumptions were made:

- Block grants to states will grow at the rate of growth in the consumer price index plus 1 percent.
- States will match this lower rate of spending growth in their share of Medicaid spending.
- States will meet these new spending limits through a 50–50 combination of cuts in per capita Medicaid costs, such as lower provider payments or reduced benefits (50%), and through reduced eligibility for the program (50%).
- States will maintain existing Medicaid eligibility for the elderly and people with disabilities, so that any eligibility cuts needed to meet spending targets will come from the reduced eligibility of people who are under age 65 and not disabled.

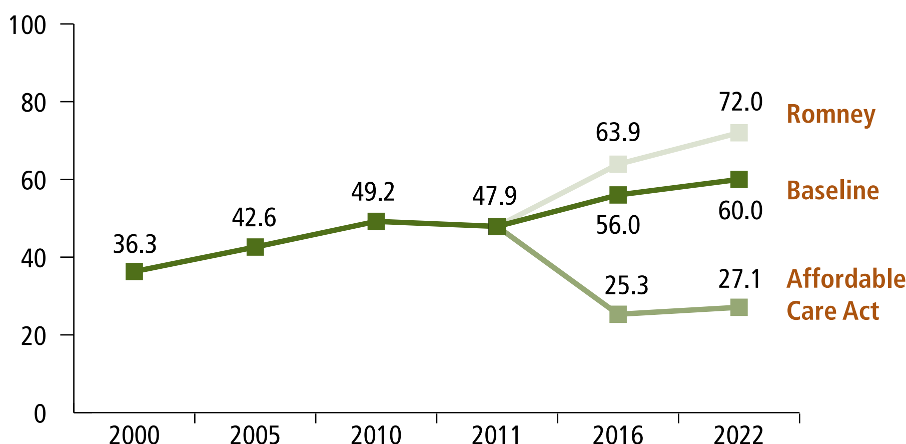
Romney has not said how he would equalize the tax treatment of employer and individually purchased health plans. People who receive premium contributions from their employers do not pay income taxes on that portion of their compensation. Different policy options have been advanced to put employer and individual market plans on an equal tax footing. For example, as a presidential candidate in 2008, Senator John McCain proposed to eliminate the existing employer tax exclusion and offer everyone a flat tax credit to buy health insurance. This analysis assumes that Romney might consider the least interventionist means of accomplishing this goal, which is to make premiums for self-purchased health insurance deductible from taxable income on an "above-the-line" basis—that is, a deduction available to all, not just those who itemize their taxes. This ensures that health insurance is treated the same way, tax-wise, regardless of its source.

The Number of Uninsured People Falls Under the Affordable Care Act and Climbs Under Romney's Proposals

When fully implemented, the Affordable Care Act is projected to substantially reduce the number and percentage of adults and children who are uninsured in every state, in every income group, and in every age group. In the absence of the Affordable Care Act—the baseline scenario in this analysis—the number of uninsured people under age 65 is projected to climb to 60 million by 2022 (Exhibit 3, Table 1). The insurance coverage provisions of the Affordable Care Act are estimated to reduce the number of uninsured by 32.9 million people by 2022, leaving 27.1 million people uninsured in 2022.

In contrast, Governor Romney's proposals are projected to increase the number and share of people who are uninsured in every state and demographic group, even compared with the baseline scenario. Nationally, Romney's proposals are estimated to increase the number of uninsured people by 12 million compared with the baseline, or no Affordable Care Act, leaving 72 million people uninsured in 2022. More than 80 percent

Exhibit 3. Numbers of Uninsured Under the Affordable Care Act and Governor Romney's Plan



Note: Baseline scenario is if the Affordable Care Act had not been enacted in 2010; Affordable Care Act is full implementation of the law; Romney plan includes full repeal of the Affordable Care Act and replacement with state block grants for the Medicaid program and equalization of the tax treatment of individually purchased health plans and employer plans.
Sources: *Income, Poverty, and Health Insurance Coverage in the United States: 2011,* U.S. Census Bureau, Sept. 2012; estimates by Jonathan Gruber and Sean Sall of MIT using the Gruber Microsimulation Model for The Commonwealth Fund.

Table 1. The Affordable Care Act and Governor Romney's Plan Compared with Baseline: Changes in Insurance Coverage and Source, 2022

Base: nonelderly ages 0–64

	Baseline		Affordable Care Act		Romney	
	Millions	Percent	Millions	Percent	Millions	Percent
Coverage*						
Group	161.0	58.2%	157.2	56.8%	158.8	57.4%
Nongroup	13.7	5.0	32.1	11.6	17.0	6.2
Public	41.9	15.1	60.3	21.8	28.8	10.4
Uninsured	60.0	21.7	27.1	9.8	72.0	26.0
Uninsured by age						
0–18	10.0	12.1	6.0	7.2	17.9	21.6
19–29	17.4	38.8	7.2	16.0	18.6	41.4
30–49	21.8	25.0	9.0	10.4	23.7	27.3
50–64	10.8	17.5	4.9	7.9	11.8	19.1
19–64	50.0	25.8	21.1	10.9	54.1	27.9
Uninsured by poverty						
<138% FPL	34.2	38.6	17.2	19.4	38.7	43.7
139%–249% FPL	13.8	28.3	3.3	6.9	17.7	36.4
250%–399% FPL	6.7	13.4	2.1	4.3	8.4	16.8
400%+ FPL	5.3	6.0	4.4	5.0	7.2	8.0
Uninsured by gender						
Male	33.2	23.7	14.4	10.3	39.2	27.9
Female	26.8	19.7	12.7	9.3	32.8	24.1

* Percents shown for source of coverage are distributions. Percents shown for uninsured by age, poverty, and gender are rates.
Note: Baseline scenario is if the Affordable Care Act had not been enacted in 2010; Affordable Care Act is full implementation of the law; Romney plan includes full repeal of the Affordable Care Act and replacement with state block grants for the Medicaid program and equalization of the tax treatment of individually purchased health plans and employer plans. FPL refers to federal poverty level.
Source: Estimates by Jonathan Gruber and Sean Sall of MIT using the Gruber Microsimulation Model for The Commonwealth Fund.

Table 2. The Affordable Care Act and Governor Romney's Plan Compared with Baseline: Changes in Insurance Coverage Source by Policy Option, 2022

Base: nonelderly ages 0–64

	Baseline	Affordable Care Act		Romney			
				Tax deduction only		Medicaid block grants only	
	Total (millions)	Total (millions)	Change (percent)	Total (millions)	Change (percent)	Total (millions)	Change (percent)
Coverage							
Group	161.0	157.2	–3.8%	156.3	–4.67%	163.6	2.55%
Nongroup	13.7	32.1	18.4	16.3	2.57	14.2	0.48
Public	41.9	60.3	18.4	42.1	0.22	28.6	–13.3
Uninsured	60.0	27.1	–32.9	61.9	1.88	70.3	10.27

Note: Baseline scenario is if the Affordable Care Act had not been enacted in 2010; Affordable Care Act is full implementation of the law; Romney plan includes full repeal of the Affordable Care Act and replacement with state block grants for the Medicaid program and equalization of the tax treatment of individually purchased health plans and employer plans. FPL refers to federal poverty level.
Source: Estimates by Jonathan Gruber and Sean Sall of MIT using the Gruber Microsimulation Model for The Commonwealth Fund.

of the increase in the uninsured (10.3 million people) stems from cuts in Medicaid eligibility because of the Medicaid block grants (Table 2). About 1.9 million people would lose coverage under the proposed income tax deduction for individually purchased coverage, since some employers would stop offering health insurance if their employees have an alternative. A similar dynamic is expected to occur after the insurance provisions of the Affordable Care Act are fully in place.

Employer-Based Coverage Remains the Primary Source of Insurance Under Both the Affordable Care Act and Romney's Proposals

Employer-based health insurance is the primary source of insurance coverage for the under-65 population. Under the baseline scenario, nearly 60 percent of people under age 65 are projected to be insured in an employer health plan, either through their own job or a family member's job. The lack of affordable options outside of employer coverage is the primary reason why there are so many uninsured people in the United States. Under both the Affordable Care Act and Governor Romney's proposals, the majority of the U.S. population under age 65 in 2022 would continue to have job-based health insurance (Exhibit 4, Table 1).

Both the Affordable Care Act and Romney's proposals would provide financial help to those who are not offered health benefits through their job. Under the health reform law, a total of 32.1 million people are projected to have "nongroup" health insurance coverage in 2022 through either the exchanges or the individual market, a total that includes 18.4 million more people compared with the baseline (no Affordable Care Act) who will gain coverage because of the combination of premium tax credits for private plans offered in state insurance exchanges and new regulations that ban all health plans—including individual plans offered outside the exchanges—from denying, limiting, or charging more for coverage because of health status. If the Romney proposal to equalize the tax treatment of health insurance was accomplished by allowing a tax deduction for individual insurance market premiums, far fewer people would have nongroup coverage: a total of 17 million people would have health coverage through the individual market, including about 3.3 million additional people covered through the individual market compared with the baseline.

Once Medicaid eligibility is expanded, as called for in the Affordable Care Act, an estimated 18.4 million additional people will gain coverage through the program, bringing the total number of people under age 65 who are enrolled in public insurance programs to 60.3 million in 2022. Under the modeling assumptions of this analysis, the Romney proposal to block-grant the Medicaid program is projected to reduce coverage in public insurance programs by 13.1 million; by 2022, a total of 28.8 million nonelderly people will be covered by public insurance. The loss of Medicaid coverage through the block grants is the primary reason why so many more people are uninsured under Romney's proposal compared with both the baseline and the Affordable Care Act.

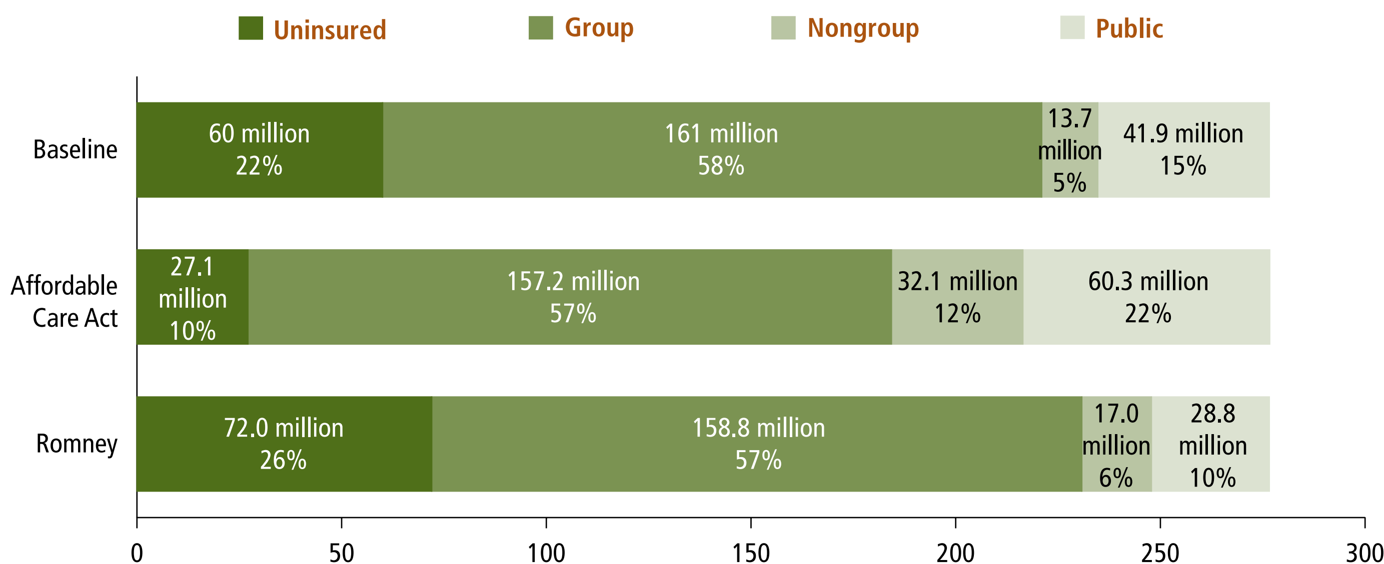
Uninsured rates climb in every age group under Romney's proposal. In 2022, uninsured rates for every age group will decline under the Affordable Care Act and increase under Governor Romney's proposal, relative to the baseline.

Children. Depending on how states responded to Medicaid block grants, coverage of children might be particularly affected. Currently, states must provide Medicaid to children under age 6 and pregnant women in families with incomes under 133 percent of the federal poverty level ($30,657 for a family of four), as well as to children up to age 19 with incomes under the poverty level ($23,050 for a family of four). But most states have used federal matching funds to substantially expand insurance coverage for children beyond those income levels.[15] Forty-five states plus the District of Columbia have expanded eligibility for children in families with incomes of 200 percent of poverty or higher.[16] Prior to passage of the Affordable Care Act, similar federal matching funds have not been available to adults without children.

States' expansions in eligibility for children, through the use of federal matching funds, have resulted in a dramatic decline in the number of uninsured children nationwide since the late 1990s, even as more adults have lost coverage over that period.[17] Medicaid and CHIP thus have been critical sources of health insurance for children in low- and moderate-income families, particularly during the economic downturn of the past few years. A recent national survey by The Commonwealth Fund found that nearly two-thirds (63%) of adults with children with incomes under 133 percent of poverty, and more than one-third of those with incomes between 133 percent and 249 percent of poverty, had some or all of their children enrolled in Medicaid or CHIP.[18]

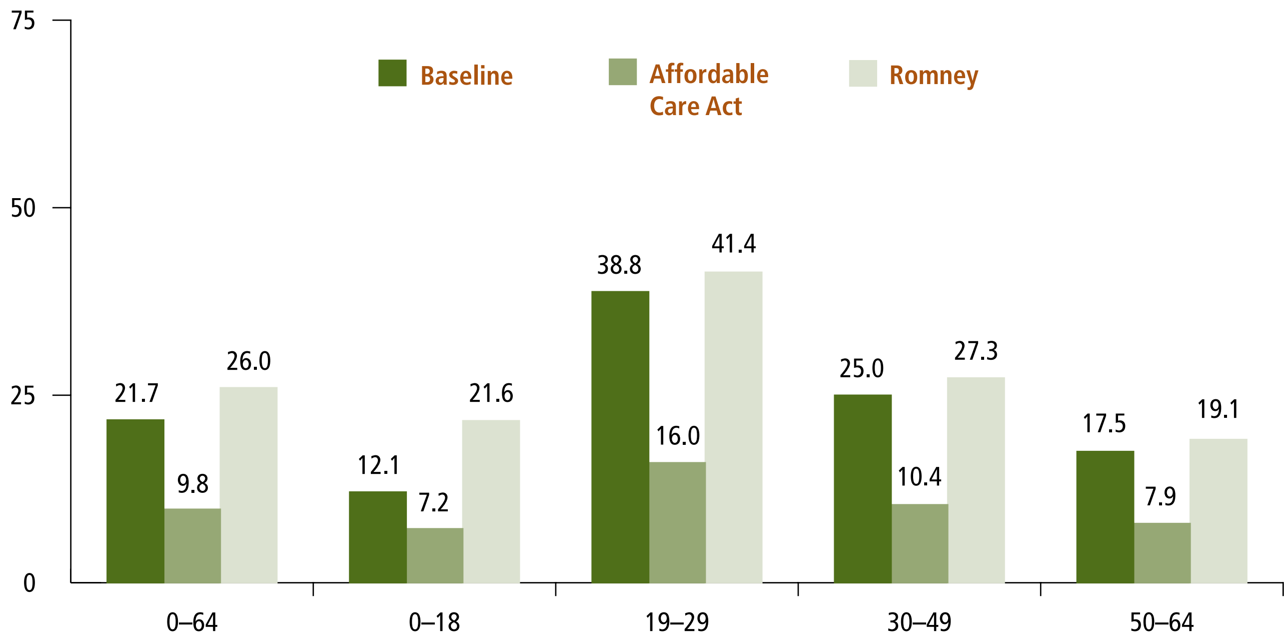
With expanded eligibility for Medicaid and income-based subsidies available for private coverage purchased through the exchanges, the percentage of uninsured children falls from 12.1 percent to 7.2 percent under the Affordable Care Act, or from an estimated 10 million uninsured children to 6 million (Exhibit 5, Table 1). In contrast, under the modeling assumptions, Romney's proposals to repeal the health reform law and block-grant the Medicaid program, combined with tax incentives applying to premiums for individual market

Exhibit 4. Source of Insurance Coverage Under the Affordable Care Act and Governor Romney's Plan Compared with Baseline, 2022



Note: Baseline scenario is if the Affordable Care Act had not been enacted in 2010; Affordable Care Act is full implementation of the law; Romney plan includes full repeal of the Affordable Care Act and replacement with state block grants for the Medicaid program and equalization of the tax treatment of individually purchased health plans and employer plans.
Source: Estimates by Jonathan Gruber and Sean Sall of MIT using the Gruber Microsimulation Model for The Commonwealth Fund.

Exhibit 5. Percent of Population Uninsured Under the Affordable Care Act and Governor Romney's Plan Compared with Baseline by Age Group, 2022



Note: Baseline scenario is if the Affordable Care Act had not been enacted in 2010; Affordable Care Act is full implementation of the law; Romney plan includes full repeal of the Affordable Care Act and replacement with state block grants for the Medicaid program and equalization of the tax treatment of individually purchased health plans and employer plans.
Source: Estimates by Jonathan Gruber and Sean Sall of MIT using the Gruber Microsimulation Model for The Commonwealth Fund.

plans, *increase* the percentage of children who are uninsured, from 12.1 percent to 21.6 percent, or from 10 million uninsured children to 17.9 million.

Young adults ages 19 to 29. Young adults have been among the age groups most at risk for lacking health insurance, either because they become ineligible for Medicaid or CHIP on their 19th birthday or they lose coverage under a parent's employer health plan when they graduate from high school or college.[19] Provisions of the Affordable Care Act have especially targeted this age group. As of 2010, all insurers and employers that offer dependent coverage are required to offer benefits to all children up to age 26, regardless of dependent status, living situation, or enrollment in an institution of higher education. Beginning in 2014, most currently uninsured young adults who cannot join a parent's health plan will be eligible for Medicaid or subsidized private health plans.

The provisions of the health reform law are estimated to reduce the share of uninsured young adults ages 19 to 29 from 38.8 percent to 16 percent under the Affordable Care Act, or from an estimated 17.4 million uninsured to 7.2 million (Exhibit 5, Table 1). In contrast, Romney's proposals to repeal the law and block-grant the Medicaid program would end the ability of many young adults to join their parents' policies, enroll in Medicaid, or join a subsidized plan through the exchanges. Consequently, uninsured rates in this age group increase to 41.4 percent under Romney's proposals, or an estimated 18.6 million uninsured young adults.

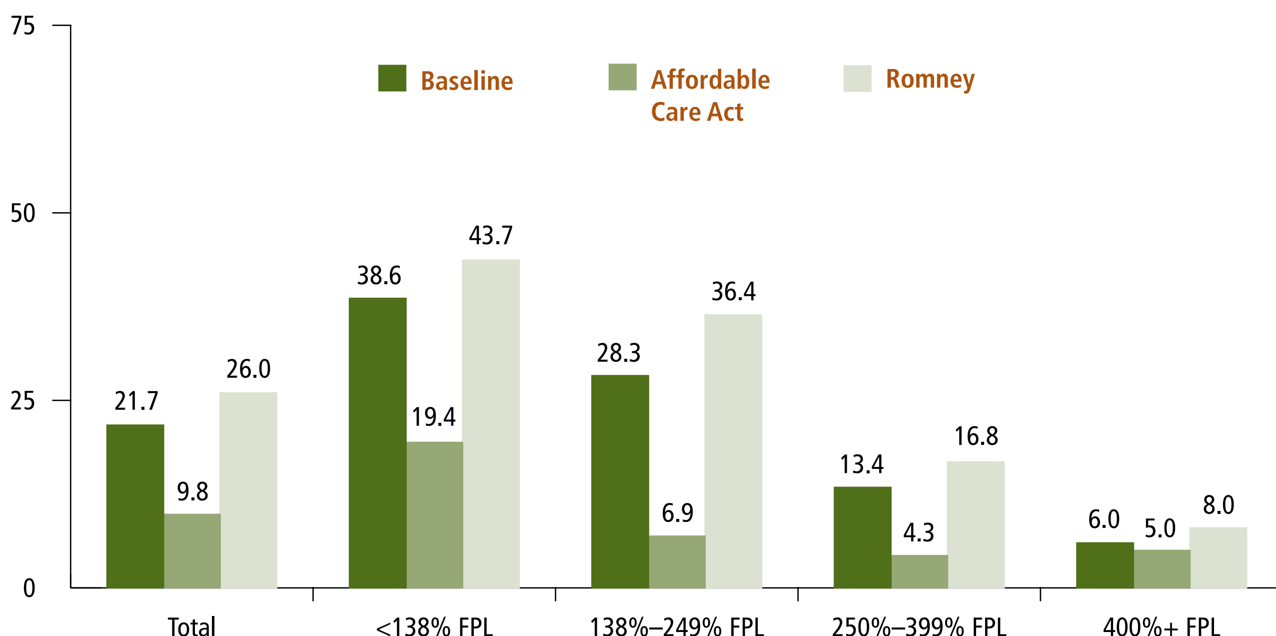
Working-age adults age 30 and over. Working-age adults age 30 and over also fare better under the reform law compared with Romney's proposals. Uninsured rates for adults between 30 and 49 are estimated to decline from 25 percent to 10.4 percent under the Affordable Care Act and increase to 27.3 percent under Romney's proposals. Among baby boomers between 50 and 64, uninsured rates are projected to decline by more than half (from 17.5% to 7.9%) under the Affordable Care Act and increase under Romney's proposals to 19.1 percent.

People with low and moderate incomes realize the greatest gains in coverage under the Affordable Care Act and the greatest losses under Romney's proposals. People with incomes under 250 percent of the poverty level, about $27,925 for a single person and $57,625 for a family of four, are the most likely to lack health insurance coverage and to be uninsured for long periods. A recent Commonwealth Fund survey found that nearly three of five (57%) adults ages 19 to 64 in families earning less than 133 percent of poverty were uninsured for a time in 2011 and two of five (41%) had been uninsured for one or more years.[20] Among adults in households with slightly higher incomes—those earning between 133 percent and 249 percent of poverty—more than one-third (36%) lacked health insurance during 2011 and nearly one-quarter (23%) had been uninsured for one or more years.

The Affordable Care Act's expansion in Medicaid eligibility and subsidies for private plan coverage are particularly designed to increase coverage among low- and moderate-income families. The Medicaid expansion is projected to decrease the proportion of people without insurance living below 138 percent of the poverty level from 38.6 percent to 19.4 percent (Exhibit 6, Table 1). In contrast, Romney's proposals to repeal the law and block-grant the Medicaid program, under the modeling assumptions, are projected to increase the proportion of people who are uninsured in this income range to nearly 44 percent.

Similarly, the subsidized private plans that will be available through new state insurance exchanges are projected to decrease the share of uninsured people with moderate incomes (up to $57,625 for a family of four). Under the Affordable Care Act, people with this level of income will be eligible for tax credits that will cap the share of income they spend on premiums at 3 percent for those at 138 percent of poverty and at 8 percent for those at 249 percent of poverty (Exhibit 2). The effect of the law on coverage in this income group is dramatic: the percentage estimated to be uninsured declines from a projected 28.3 percent in 2022 in the absence of the Affordable Care Act to 6.9 percent (Exhibit 6). In

Exhibit 6. Percent of Population Uninsured Under the Affordable Care Act and Governor Romney's Plan Compared with Baseline by Poverty, 2022



Note: Baseline scenario is if the Affordable Care Act had not been enacted in 2010; Affordable Care Act is full implementation of the law; Romney plan includes full repeal of the Affordable Care Act and replacement with state block grants for the Medicaid program and equalization of the tax treatment of individually purchased health plans and employer plans. FPL refers to federal poverty level.
Source: Estimates by Jonathan Gruber and Sean Sall of MIT using the Gruber Microsimulation Model for The Commonwealth Fund.

contrast, Governor Romney's proposal to repeal the law and replace it with tax incentives for coverage purchased in the individual market and Medicaid block grants is estimated to increase the percentage of adults and children uninsured in this income range to 36.4 percent.

People with higher incomes also are projected to fare better under the Affordable Care Act than they would under Romney's proposals. Under the reform law, people with incomes between 250 percent and 399 percent of the poverty level (up to $44,680 for a single person to $92,200 for a family of four) will be eligible for tax credits that will cap the share of income they spend on premiums at 8 percent for those at 250 percent of poverty and at 9.5 percent for those at 300 percent to 400 percent of poverty. The percentage of people in this income range who are uninsured declines from a projected 13.4 percent in 2022 in the absence of the Affordable Care Act to 4.3 percent. The Romney proposals, on the other hand, are estimated to increase the percentage of adults and children uninsured in this income range to about 17 percent.

People living at 400 percent of the poverty level and above will not be eligible for premium tax credits under the reform law. But the new consumer protections in the law will require insurers to issue health plans to everyone who applies, prevent carriers from denying or restricting coverage based on preexisting health conditions, and ban the practice of charging higher premiums based on health status or gender. Romney's proposal to repeal the law will eliminate these protections. While some people would benefit from his proposed tax incentives for plans purchased on the individual market, those who are uninsured would likely encounter the same problems they currently face buying plans in the market today. Under the Affordable Care Act, the uninsured rate for this income group drops slightly, from 6 percent to 5 percent; under Romney, this rate increases to about 8 percent.

People living in the South and West are projected to make the biggest gains in coverage under the Affordable Care Act; states with generous Medicaid programs could see the largest losses in coverage under Romney. In every state, the percentage of people under age 65 who are uninsured declines in 2022 under the Affordable Care Act and increases under Governor Romney's proposals, relative to the baseline. But there is variation in both the degree of the decrease in the uninsured under the reform law and the increase in the uninsured under Romney's proposals. States that achieve the greatest declines in uninsured rates under the Affordable Care Act have the highest rates of people without health insurance under the baseline. States that realize the biggest losses in coverage under the Romney proposals tend to have more generous Medicaid programs and thus stand to lose the most federal funding under a block-grant approach to financing.

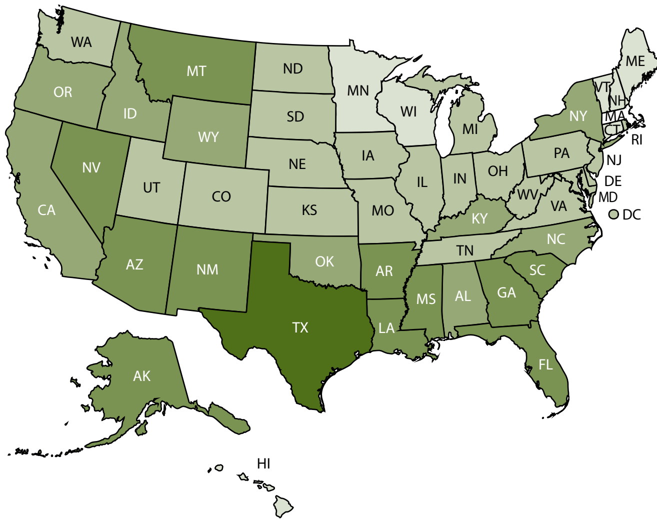
People under age 65. Led by Texas, with 31 percent of its under-65 population uninsured, states in the southern and western regions of the U.S. are projected to have the highest percentages of uninsured people in the country in the baseline scenario, or in the absence of the Affordable Care Act in 2022 (Exhibit 7, Table 3). In addition to Texas, there are 11 states where a quarter or more of the population is projected to be uninsured, without the law, in 2022: Alaska, Arizona, Arkansas, Florida, Georgia, Louisiana, Mississippi, Montana, Nevada, New Mexico, and South Carolina. One-fifth to one-quarter of the nonelderly population are projected to be uninsured in nine other states: Alabama, California, Idaho, Kentucky, North Carolina, New York, Oklahoma, Oregon, and Wyoming.

The new subsidized coverage options and insurance market rules in the Affordable Care Act are estimated to reduce the percentage of people uninsured in each state, with particularly significant declines in those states where a large share of the population is uninsured. Uninsured rates for people under age 65 are projected to fall from 21.7 percent to 9.8 percent nationally by 2022, ranging from a low of 4.7 percent in Maine to a high of 14.7 percent in Texas. The law is projected to reduce the uninsured rate to 10 to 15 percent in 11 states across the South and West, and in New York and the District of Columbia; in the rest of the states, uninsured rates will be under 10 percent.

In many states, the law is projected to result in dramatic declines in the uninsured. Uninsured rates in 11 states are estimated to fall by more than 15 percentage points from projected levels (Alaska, Arkansas, Florida, Georgia, Idaho, Louisiana,

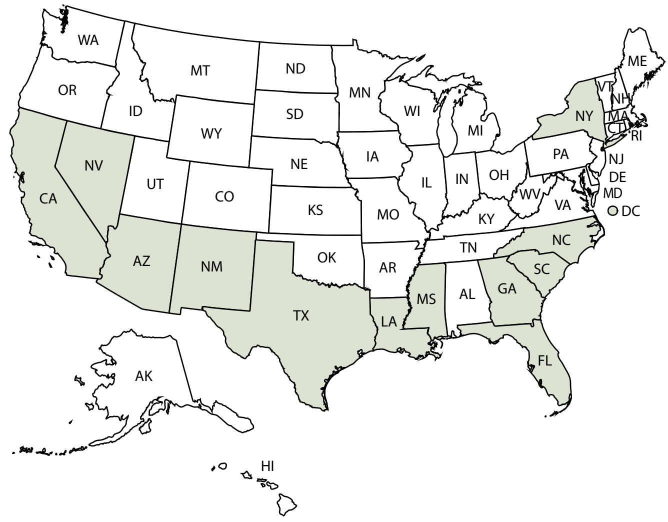
Exhibit 7. Uninsured Nonelderly Under Baseline and the Affordable Care Act in 2022, by State

Baseline



22% of nonelderly uninsured

Affordable Care Act

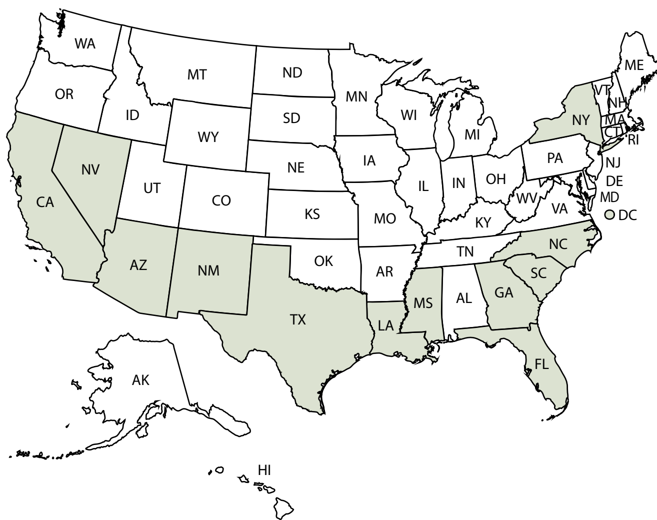


10% of nonelderly uninsured

Note: Baseline scenario is if the Affordable Care Act had not been enacted in 2010; Affordable Care Act is full implementation of the law; Romney plan includes full repeal of the Affordable Care Act and replacement with state block grants for the Medicaid program and equalization of the tax treatment of individually purchased health plans and employer plans.
Source: Estimates by Jonathan Gruber and Sean Sall of MIT using the Gruber Microsimulation Model for The Commonwealth Fund.

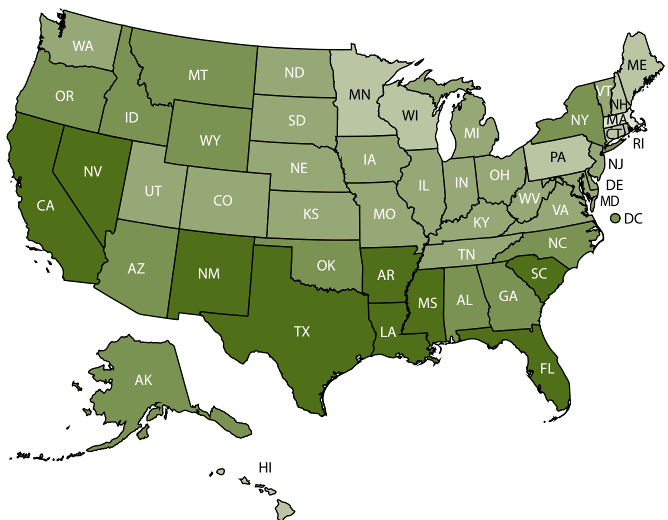
Exhibit 8. Uninsured Nonelderly Under the Affordable Care Act and Governor Romney's Plan in 2022, by State

Affordable Care Act



10% of nonelderly uninsured

Romney



26% of nonelderly uninsured

Note: Baseline scenario is if the Affordable Care Act had not been enacted in 2010; Affordable Care Act is full implementation of the law; Romney plan includes full repeal of the Affordable Care Act and replacement with state block grants for the Medicaid program and equalization of the tax treatment of individually purchased health plans and employer plans.
Source: Estimates by Jonathan Gruber and Sean Sall of MIT using the Gruber Microsimulation Model for The Commonwealth Fund.

Table 3. The Affordable Care Act and Governor Romney's Plan: Changes in the Uninsured Population in 2022

Base: nonelderly ages 0–64

		Total uninsured						Percentage point change in uninsured	
		Baseline		Affordable Care Act		Romney			
State	Total population ages 0–64	Number	Percent	Number	Percent	Number	Percent	Baseline to Affordable Care Act	Baseline to Romney
Alabama	4,010,000	830,000	20.7	310,000	7.7	1,010,000	25.2	–13.0	4.5
Alaska	600,000	150,000	25.0	50,000	8.3	170,000	28.3	–16.7	3.3
Arizona	6,170,000	1,550,000	25.1	690,000	11.2	1,830,000	29.7	–13.9	4.5
Arkansas	2,540,000	640,000	25.2	210,000	8.3	770,000	30.3	–16.9	5.1
California	34,840,000	8,580,000	24.6	4,250,000	12.2	10,650,000	30.6	–12.4	5.9
Colorado	4,580,000	800,000	17.5	390,000	8.5	1,020,000	22.3	–9.0	4.8
Connecticut	3,220,000	450,000	14.0	260,000	8.1	590,000	18.3	–5.9	4.3
Delaware	780,000	120,000	15.4	60,000	7.7	170,000	21.8	–7.7	6.4
District of Columbia	560,000	90,000	16.1	60,000	10.7	140,000	25.0	–5.4	8.9
Florida	15,850,000	4,580,000	28.9	1,940,000	12.2	5,150,000	32.5	–16.7	3.6
Georgia	8,910,000	2,280,000	25.6	930,000	10.4	2,510,000	28.2	–15.2	2.6
Hawaii	1,030,000	120,000	11.7	70,000	6.8	170,000	16.5	–4.9	4.9
Idaho	1,420,000	350,000	24.6	110,000	7.7	400,000	28.2	–16.9	3.5
Illinois	11,940,000	2,280,000	19.1	1,040,000	8.7	2,770,000	23.2	–10.4	4.1
Indiana	5,550,000	1,020,000	18.4	350,000	6.3	1,270,000	22.9	–12.1	4.5
Iowa	2,720,000	440,000	16.2	210,000	7.7	550,000	20.2	–8.5	4.0
Kansas	2,410,000	430,000	17.8	190,000	7.9	530,000	22.0	–10.0	4.1
Kentucky	3,780,000	780,000	20.6	350,000	9.3	900,000	23.8	–11.4	3.2
Lousiana	4,060,000	1,100,000	27.1	440,000	10.8	1,270,000	31.3	–16.3	4.2
Maine	1,060,000	150,000	14.2	50,000	4.7	200,000	18.9	–9.4	4.7
Maryland	5,330,000	900,000	16.9	500,000	9.4	1,080,000	20.3	–7.5	3.4
Massachusetts	5,760,000	470,000	8.2	340,000	5.9	700,000	12.2	–2.3	4.0
Michigan	8,840,000	1,530,000	17.3	570,000	6.4	1,950,000	22.1	–10.9	4.8
Minnesota	4,680,000	610,000	13.0	330,000	7.1	840,000	17.9	–6.0	4.9
Mississippi	2,630,000	750,000	28.5	280,000	10.6	820,000	31.2	–17.9	2.7
Missouri	5,440,000	1,010,000	18.6	370,000	6.8	1,180,000	21.7	–11.8	3.1
Montana	830,000	210,000	25.3	70,000	8.4	240,000	28.9	–16.9	3.6
Nebraska	1,600,000	290,000	18.1	130,000	8.1	350,000	21.9	–10.0	3.8
Nevada	2,440,000	670,000	27.5	340,000	13.9	740,000	30.3	–13.5	2.9
New Hampshire	1,190,000	160,000	13.4	80,000	6.7	200,000	16.8	–6.7	3.4
New Jersey	8,010,000	1,590,000	19.9	670,000	8.4	1,920,000	24.0	–11.5	4.1
New Mexico	1,790,000	520,000	29.1	240,000	13.4	570,000	31.8	–15.6	2.8
New York	17,530,000	3,670,000	20.9	2,120,000	12.1	4,720,000	26.9	–8.8	6.0
North Carolina	8,260,000	1,920,000	23.2	890,000	10.8	2,200,000	26.6	–12.5	3.4
North Dakota	570,000	100,000	17.5	40,000	7.0	120,000	21.1	–10.5	3.5
Ohio	10,260,000	1,850,000	18.0	740,000	7.2	2,410,000	23.5	–10.8	5.5
Oklahoma	3,170,000	750,000	23.7	280,000	8.8	840,000	26.5	–14.8	2.8
Oregon	3,450,000	740,000	21.4	290,000	8.4	870,000	25.2	–13.0	3.8
Pennsylvania	10,950,000	1,650,000	15.1	740,000	6.8	2,180,000	19.9	–8.3	4.8
Rhode Island	920,000	140,000	15.2	60,000	6.5	180,000	19.6	–8.7	4.3
South Carolina	4,010,000	1,110,000	27.7	420,000	10.5	1,270,000	31.7	–17.2	4.0
South Dakota	710,000	130,000	18.3	40,000	5.6	150,000	21.1	–12.7	2.8
Tennessee	5,540,000	1,100,000	19.9	510,000	9.2	1,320,000	23.8	–10.6	4.0
Texas	23,870,000	7,410,000	31.0	3,500,000	14.7	8,190,000	34.3	–16.4	3.3
Utah	2,640,000	470,000	17.8	210,000	8.0	530,000	20.1	–9.8	2.3
Vermont	550,000	70,000	12.7	40,000	7.3	110,000	20.0	–5.5	7.3
Virginia	6,770,000	1,310,000	19.4	490,000	7.2	1,480,000	21.9	–12.1	2.5
Washington	5,800,000	1,140,000	19.7	460,000	7.9	1,370,000	23.6	–11.7	4.0
West Virginia	1,560,000	300,000	19.2	100,000	6.4	370,000	23.7	–12.8	4.5
Wisconsin	4,980,000	630,000	12.7	260,000	5.2	900,000	18.1	–7.4	5.4
Wyoming	490,000	110,000	22.4	40,000	8.2	130,000	26.5	–14.3	4.1

Note: Baseline scenario is if the Affordable Care Act had not been enacted in 2010; Affordable Care Act is full implementation of the law; Romney plan includes full repeal of the Affordable Care Act and replacement with state block grants for the Medicaid program and equalization of the tax treatment of individually purchased health plans and employer plans. FPL refers to federal poverty level.
Source: Estimates by Jonathan Gruber and Sean Sall of MIT using the Gruber Microsimulation Model for The Commonwealth Fund.

Mississippi, Montana, New Mexico, South Carolina, and Texas) (Table 3).

Romney's plans for health care are expected, on balance, to worsen health insurance coverage in every state. Under the assumption that states respond to his proposed reductions in federal Medicaid financing by combining, in equal parts, lower per-capita program spending, through such changes as lower provider reimbursement or cuts in benefits, with reduced eligibility, an estimated nine states, mostly in the South and West, could see 30 percent or more of their under-age-65 population without health coverage by 2022 (Exhibit 8, Table 3). In an additional 11 states plus the District of Columbia, 25 percent to 30 percent of the under-65 population may be uninsured in 2022. Overall, a quarter or more of the under-65 population in 21 states might be without health insurance in 2022, were Romney's proposals to become law.

States that have more generous Medicaid eligibility standards for children, pregnant women, parents, and childless adults are expected to experience greater reductions in insurance coverage under Romney's proposals, as the federal matching funds that enabled the expansions are converted to block grants. States will have far less funding to spread across all the groups of people who are currently served by Medicaid: elderly Americans with modest incomes, people living in nursing homes, adults and children with disabilities, children and pregnant women, and low-income adults, including those with and without children. Many of the states that are projected to experience the biggest percentage-point increase in their uninsured rates (five points or greater)—Arkansas, California, Delaware, District of Columbia, Maine, New York, Ohio, Vermont, and Wisconsin—have among the nation's highest income eligibility limits (Table 3).[21]

2. Will the Candidates' Plans Make Health Insurance More Affordable?

The Problem

People who are not offered employer-sponsored coverage and are not eligible for public insurance programs are largely limited to purchasing coverage in the individual market. But the individual market for most Americans is neither affordable nor easy to navigate. People buying coverage in this market must pay the full premium and, under current laws in most states, may pay higher premiums based on their health, gender, and age. They can also be denied coverage because of a preexisting condition or have their condition excluded from their health plan.[22] A recent Commonwealth Fund study found that nearly one-third of adults who had tried to buy a plan in the individual market in the past three years had been turned down, charged a higher premium, or had a condition excluded from their plan because of a health condition. Forty-five percent never ended up buying a plan, with 62 percent citing high premium costs as the main reason they had decided against buying a plan.[23]

The Candidates' Solutions

President Obama: The Affordable Care Act

If reelected, President Obama would continue to implement the Affordable Care Act, which will provide new affordable health insurance options through the state insurance exchanges. Starting in January 2014, insurance market rules will prevent health insurers from denying or limiting coverage, or charging higher premiums based on health or gender. People not offered affordable health insurance through their jobs will have a choice of private health plans sold through the exchanges that offer a comprehensive set of benefits known as the "essential benefit package." The scope of benefits provided must be equivalent to that offered in a typical employer plan. Insurers will offer these plans at four levels of cost-sharing: bronze plans (covering on average 60% of someone's annual medical costs), silver (70% of costs), gold (80% of costs), and platinum (90% of costs), but benefits will be the same within and across each of the four tiers.

To improve the affordability of health insurance for those who do not have job-based health benefits, the federal government will provide a tax credit to offset the cost of premiums for private health plans purchased through the insurance exchanges for people with household incomes between 100 percent and 400 percent of the federal poverty level ($23,050 to $92,200 for a family of four) (Exhibit 2). People at up to 138

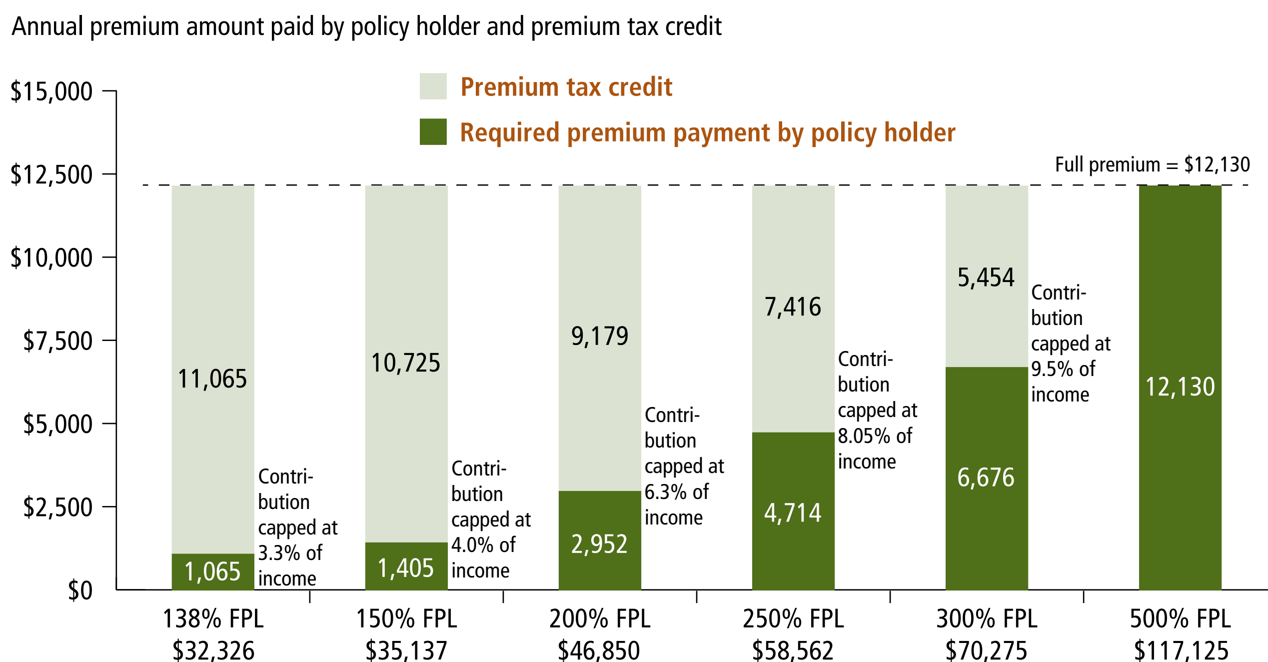
percent of the poverty level ($15,415 for an individual and $31,809 for a family of four) will generally be eligible to enroll in Medicaid, although by virtue of this summer's Supreme Court decision, states may decide whether or not they will participate in the law's Medicaid expansion (see box on page 23). For people with low incomes, the average costs covered by the silver plan will be increased to 94 percent (for those with incomes up to 149% of poverty), 87 percent (150% to 199% of poverty), and 73 percent (200% to 249% of poverty). Out-of-pocket spending limits will also be lower for people with incomes under 400 percent of poverty.

Taxpayers eligible for insurance premium tax credits are required to contribute no more than 2 percent to 9.5 percent of their income toward their premium. The amount of the credit will be equal to the difference between someone's required premium contribution and the premium of the benchmark health plan—the second-lowest-cost "silver plan" offered through the exchange.[24] This means that someone may choose a plan that is not the benchmark plan, but the amount of the tax credit will be determined based on the premium for the benchmark plan, not the plan they enroll in, which could be less or more than the benchmark. In addition, the tax credit amount cannot exceed the amount of the full premium.

To illustrate, a family of four has an income of $35,137, putting them at 150 percent of the poverty level in 2014 (Exhibit 9). Their required premium contribution would be 4 percent of income, or $1,405. For a 40-year-old policyholder, the Kaiser Family Foundation estimates that this family's premium for a benchmark plan in a medium-cost area of the country would be about $12,130. The family's tax credit would thus be equal to the benchmark premium minus their required contribution, or $10,725. A family with slightly older parents would be charged a higher premium in the exchange. But the tax credit would also be higher, since the premium contribution for the family is a fixed share of its income.

For consumers who do not have health insurance through a job, this combination of new subsidies, rules for insurance carriers, and standardized choices of plans with well-defined benefits and cost-sharing responsibilities represents a marked change

Exhibit 9. Annual Premium Amount and Tax Credits for a Family of Four Under the Affordable Care Act, 2014



Notes: For an family of four, policy holder age 40, in a medium-cost area in 2014. Premium estimates are based on an actuarial value of 0.70. Actuarial value is the average percent of medical costs covered by a health plan. FPL refers to federal poverty level.
Source: Premium estimates are from Kaiser Family Foundation Health Reform Subsidy Calculator http://healthreform.kff.org/Subsidycalculator.aspx.

from the past. Jon Gabel and colleagues recently found that 51 percent of people enrolled in plans purchased in the individual market in five states had plans with such limited benefits or high cost-sharing that they would not qualify to be sold either through the exchanges or the individual market in 2014.[25] Maternity services in particular are rarely included in health plans purchased on the individual market: currently, 62 percent of individual market enrollees do not have maternity coverage.[26] Health plans will be required to include maternity benefits starting in 2014.

Governor Romney

If elected, Governor Romney has pledged to repeal the Affordable Care Act and replace it in part by equalizing the tax treatment of employer coverage and plans purchased in the individual insurance market. Under current tax law, employer premium contributions are exempt from both income and payroll taxes.[27] In addition, people who are self-employed can deduct the cost of their health insurance premiums on their tax returns on an above-the-line basis, subtracting the costs from their adjusted gross income, even if they do not itemize deductions. But people who buy health insurance coverage on their own through the individual market can deduct premium costs only if they itemize deductions and their medical expenses are greater than 7.5 percent of adjusted gross income. While Romney has not said how he would equalize the tax treatment of health insurance, others have proposed allowing everyone who purchases health insurance on their own to take an above-the-line deduction. In 2008, CBO estimated that this approach could extend health insurance to about 700,000 people.[28]

How the Candidates' Solutions Stack Up on Affordability of Insurance Coverage

This analysis compares the Affordable Care Act's insurance market regulations, including its rules against rating or denying coverage based on health and its insurance premium and cost-sharing tax credits, with Governor Romney's proposal to repeal the law, including the market reforms, and replace it with a mechanism to equalize the tax treatment of employer coverage and individual market plans. In this comparison, we assume that Romney would equalize the tax treatment of employer and individually purchased health plans by making premiums for self-purchased insurance deductible from federal income taxes on an above-the-line basis.

The Affordable Care Act's premium tax credits provide larger subsidies for more people compared with an income tax deduction for individual insurance. An estimated 20 million people are projected to be eligible for premium tax credits for health plans sold through the insurance exchanges by 2016 (Exhibit 10). The credits'

Exhibit 10. Premium Tax Credits and Tax Deductions Under the Affordable Care Act and Governor Romney's Plan, 2016

Nonelderly population, ages 0–64

	Affordable Care Act (tax credits)	Romney (tax deductions)
Number of tax credit/deduction recipients		
Among those previously uninsured	10.4 million	1 million
Among those previously insured	9.9 million	8.9 million
Average tax credit/deduction per recipient		
Among those previously uninsured	$3,928.91	$1,880.00
Among those previously insured	$4,548.84	$2,567.75
Total dollars of tax credits/deductions		
Among those previously uninsured	$40.9 billion	$1.9 billion
Among those previously insured	$45.2 billion	$22.9 billion

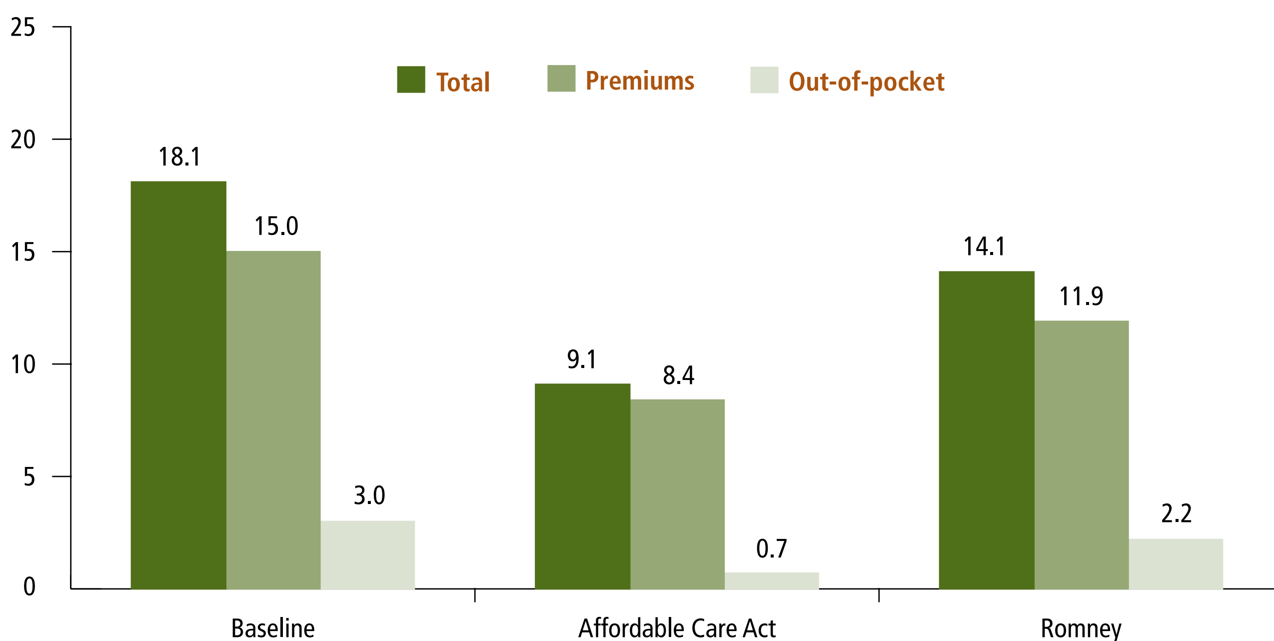
Note: Baseline scenario is if the Affordable Care Act had not been enacted in 2010; Affordable Care Act is full implementation of the law; Romney plan includes full repeal of the Affordable Care Act and replacement with state block grants for the Medicaid program and equalization of the tax treatment of individually purchased health plans and employer plans.
Source: Estimates by Jonathan Gruber and Sean Sall of MIT using the Gruber Microsimulation Model for The Commonwealth Fund.

beneficiaries are expected to be split evenly between people who previously did not have insurance and those who did, with the average per-person tax credit estimated at $3,929 for the former and $4,549 for the latter. The higher tax credit for the previously insured reflects a slightly older group whose members face somewhat higher premiums. The total federal cost of the tax credits in 2016 is estimated at $86 billion.

If Romney were to allow a tax deduction for premiums for plans purchased in the individual insurance market, it would benefit about half the number of people (10 million) that would be eligible for premium tax credits under the Affordable Care Act. The primary beneficiaries of the deduction would be those who previously had coverage; only about 1 million people who were previously uninsured would take the deduction, which is consistent with CBO's estimate in 2008. The average value of this tax deduction is also considerably lower than that of the reform law's tax credits—$1,880 for the previously uninsured and $2,568 for the previously insured. (Again, the difference in the value of the deduction reflects the relatively older age of the previously insured group.) The combination of fewer beneficiaries and the deduction's lower value results in projected federal costs that are lower than those for the tax credits—about $25 billion in 2016.

Average out-of-pocket spending, as a share of income, for nongroup coverage declines with premium tax credits and with a tax deduction for premiums. In the absence of the Affordable Care Act—the baseline scenario—people buying coverage in the individual market are estimated to spend, on average, 18.1 percent of their income on health insurance premiums (15%) and out-of-pocket costs (3%) in 2016 (Exhibit 11). Under the Affordable Care Act, the combination of premium and cost-sharing tax credits, out-of-pocket limits, and new rules governing insurance markets reduce out-of-pocket spending for plans purchased through the exchanges or the individual market to 9.1 percent of income, on average, including 8.4 percent of income on premiums and 0.7 percent on out-of-pocket costs.

Exhibit 11. Average Percent of Income Spent on Health Care in the Nongroup Market Under the Affordable Care Act and Governor Romney's Plan Compared with Baseline, 2016



Note: Baseline scenario is if the Affordable Care Act had not been enacted in 2010; Affordable Care Act is full implementation of the law; Romney plan includes full repeal of the Affordable Care Act and replacement with state block grants for the Medicaid program and equalization of the tax treatment of individually purchased health plans and employer plans.
Source: Estimates by Jonathan Gruber and Sean Sall of MIT using the Gruber Microsimulation Model for The Commonwealth Fund.

Relative to the baseline scenario, Governor Romney's income tax deduction would lower the average share of income people spend on health insurance premiums and out-of-pocket costs to 14.1 percent, including 11.9 percent for premiums and 2.2 percent for out-of-pocket costs.

3. Will the Candidates' Plans Protect Consumers?

The Problem

As currently configured in most states, the individual insurance market serves neither consumers nor insurance carriers well. Because there are no subsidies or automatic enrollment mechanisms, as there are in employer-based group insurance, people without employer health benefits may wait until they are sick and need of health care before buying an insurance policy. Carriers will therefore attempt to protect themselves against this risk, known as adverse selection, by assessing the health risk profile of each individual who applies for coverage. While some states have instituted laws to ban or limit the practice of underwriting, the vast majority of states have not done so. This means that consumers are at risk of being charged higher premiums for a history of even minor health problems, for being in occupations that carry health risks, or for being older or female, among other factors. Insurers may also exclude health conditions from coverage or deny health insurance altogether. This inherent failure of the individual insurance market has been a root cause of soaring uninsured rates in the United States, aggressive growth in insurance administrative costs, and high premium rates. A similar dynamic is at work in the small-employer group market.

The Candidates' Solutions

President Obama: The Affordable Care Act

To protect consumers, improve the functioning of health insurance markets, and reduce the wasteful costs of risk-rating insurance policies, the Affordable Care Act initiated a set of sweeping reforms of the individual and small-group insurance markets that began to take effect in 2010 and will continue through 2014. Nearly all states have taken legislative or regulatory steps to implement the law's "Patient's Bill of Rights," which went into effect in 2010.[29] The new requirements, which benefit people with individual market coverage as well as those enrolled in group insurance plans, stipulate that:

- Insurers can no longer place limits on what health plans will pay over a lifetime: 105 million people with such limits have benefitted.[30]
- Annual limits on what health plans will pay are to be phased out: 18 million people had such limits on their plans prior to the law. Limits are set at no less than $2 million and will be phased out completely by 2014.[31]
- Carriers cannot cancel policies retroactively: 10,000 people had policies rescinded each year prior to the law's passage.[32]
- Health plans must cover recommended preventive care without cost-sharing, including a new set of preventive services for women: 54 million people have benefitted, including 20 million women.[33]
- Health plans are banned from imposing preexisting condition exclusions for children: 17.6 million children benefitted.[34]

Beginning in 2014, insurers will no longer be able to deny or restrict coverage based on preexisting health conditions and will be prohibited from charging higher premiums based on health status or gender. Insurance carriers can increase premiums for older people, but by no more than three times what is charged a younger person for a similar plan. People who are eligible for tax credits will not pay more because they are older; in fact, their tax credits will be larger. All plans sold through the exchanges and in the individual and small-group markets will be required to include a new essential health benefit package similar to those offered in employer plans.

Governor Romney

The Romney campaign has pledged to repeal the Affordable Care Act and all the law's insurance market reforms and consumer protections, including those that have already gone into effect. Romney would leave the regulation of state insurance markets to states, as is the case today. He says he would allow people with

preexisting conditions to maintain their health insurance as long as they are insured continuously. The federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), currently aims to achieve this by preventing both group and individual market health plans from excluding coverage of preexisting conditions for people who have been insured continuously.

How the Candidates' Solutions Stack Up on Consumer Protections

Governor Romney's proposal to repeal the law would leave consumers who must buy coverage on their own, as well as those enrolled in employer group plans, with far fewer protections than they have today, given the large number of Affordable Care Act provisions that have already gone into effect. Carriers would continue the practice of underwriting, and consumers and insurance carriers would continue to face often prohibitively high costs when attempting to buy and sell insurance in the individual and small-group markets. The ban on preexisting condition exclusions in the Affordable Care Act offers much broader protection to consumers than those currently provided by HIPAA. Romney has not yet clarified how he would strengthen protections for people with preexisting conditions who are insured continuously beyond the HIPAA provisions.

4. Will the Candidates' Plans Improve Consumer Choice?

The Problem

Besides cost and underwriting, the most significant challenges that consumers face when buying health plans on their own is a lack of information about the plans that are available. Benefits can vary widely from plan to plan, and cost-sharing responsibilities and limits on coverage can be difficult to assess at the point of purchase. In a recent Commonwealth Fund survey, 60 percent of adults who had looked for a health plan in the individual market in the past three years said they found it very or somewhat difficult to compare the benefits covered by different plans and 55 percent said it was very or somewhat difficult to compare premium costs among plans.[35] Nearly two-thirds (65%) found it very or somewhat difficult to determine differences in their cost-sharing responsibilities and out-of-pocket liability. Small employers face similar difficulties in gathering information about health plans and thus rely heavily on insurance brokers, which increases the cost of providing health insurance to their employees.

The Candidates' Solutions

President Obama: The Affordable Care Act

Under the Affordable Care Act, people with coverage through their jobs will be able to maintain that coverage as long as it is offered to them. People without employer health benefits, as well as small businesses, will be able to visit an insurance exchange in their state, either online or in person, and select a health plan from a menu. All plans will include the same package of essential health benefits, but the plans will represent four different levels of "actuarial value," or the percentage of health costs that a plan pays for on average. The actuarial value of a plan will be designated as bronze, silver, gold, or platinum—which covers the highest share of health costs. The new exchanges, which will certify plans to be sold through their marketplaces, are required to provide additional information about plans, including:

- premium and cost-sharing information;
- a summary of benefits and coverage that meets new standardized criteria developed by the U.S. Department of Health and Human Services (HHS);
- the level of coverage offered by a qualified plan, whether bronze, silver, gold, platinum, or catastrophic;
- an electronic cost-calculator enabling people to compare coverage costs in available plans after the application of any advance payments of premium tax credits and cost-sharing reductions;[36]
- results of the enrollee satisfaction surveys that must be conducted under the law;
- the quality ratings that will be assigned to health plans;
- the percentage of premiums that plans spend on medical care, as opposed to profits and overhead (medical loss ratios), which must be reported to HHS; and
- a provider directory.

In addition, states must ensure that people with limited English proficiency have "meaningful access" to plan information.

Governor Romney

Governor Romney would work to repeal the Affordable Care Act, including the insurance exchanges, health plan standards, and plan quality ratings and other comparative information. He would replace these provisions with other consumer choice innovations: 1) allowing consumers to purchase health coverage across state lines, 2) allowing people with health savings accounts to use them to pay premiums, and 3) encouraging *Consumer Reports*–type ratings of alternative insurance plans.

While Romney has not specified details for the first proposal, other similar proposals would allow insurance carriers to choose a state to be licensed in and sell coverage in all other states, without having to comply with the regulations in each state.[37] Under such a policy, insurers would likely choose to be licensed in states with fewer regulations, such as benefit requirements and consumer protections. Because insurance carriers could sell policies in any state and not have to comply with regulations in other states, healthier consumers in states with more stringent consumer protections, such as bans on preexisting condition exclusions or restrictions on rating premiums based on health, would likely choose what would likely be lower-cost plans that skirted such regulations. CBO has estimated that over time such a policy would lead to fewer consumer protections across all states, higher premiums for enrollees in poor health, and lower premiums for people in better health. An estimated 600,000 people would gain health insurance and about 200,000 would lose coverage.

Romney's second proposal would allow people to pay insurance premiums with pretax contributions to health savings accounts (HSAs). HSAs are medical savings instruments which may be coupled with health plans that have high deductibles of at least $1,200 for an individual policy. Currently, people can use the accounts to pay out-of-pocket expenses tax-free, on the theory that this will encourage consumers to be more selective in their choices of providers and services, and lead, in the aggregate, to lower health spending over time. Employer contributions to HSAs are not taxed and contributions from individuals to the accounts can be deducted from adjusted gross income, on an above-the-line basis. Allowing people to also pay their premiums with pretax dollars would help equalize the tax treatment of insurance coverage between employer group and individual market insurance, one of Romney's goals. A recent House bill would allow former employees of companies with HSA plans between the ages of 55 and 64 to pay their premiums tax-free with their HSAs. CBO estimates that the provision for that group would cost about $2 billion over 2012–2022.[38]

How the Candidates' Solutions Stack Up on Consumer Choice

Both President Obama and Governor Romney emphasize that they would preserve and enhance consumer choice. But they take different approaches. The Romney proposal to encourage *Consumer Reports*–type ratings for health plans is similar to what will be required by state insurance exchanges beginning in 2014. He has not said, however, how he would implement his idea. Romney would also open up state insurance markets to people and businesses living in any state. This would provide greater choice to people who are young and/or healthy, but could limit choices for people who are older and/or in poorer health. Allowing people to pay premiums with HSA contributions might expand choices for some people who must buy coverage on their own.

The Affordable Care Act makes important strides in providing consumers in the individual market with far more information about their health plans than they have today. The degree to which decisions are simplified will depend on several implementation decisions. These include: 1) the extent to which the essential benefit package is standardized, such that the only variable that consumers and small businesses will need to focus on are average cost protections across benefit tiers; and 2) the proliferation of plans with widely different cost-sharing options within the same benefit tier, which would complicate consumer decision-making.[39]

5. Will the Candidates' Plans Help Small Businesses?

The Problem

Health coverage for employees in small businesses—those with 50 or fewer employees—has been a serious problem in the U.S. Because small firms face higher premiums than large firms for comparable benefits, they are less likely to offer coverage.[40] Ninety-eight percent of large firms with 200 or more workers report offering health benefits, compared with only half of those with fewer than 10 employees.[41] The substantial differential in costs between large and small firms is driven by higher administrative costs, greater per-employee costs of offering coverage, and underwriting in many states that can lead to more costly premiums for sicker, older, or female-dominated workforces.[42] On average, small firms pay up to 18 percent more in premiums than large firms do for the same health insurance policy.[43] In these plans, a higher share of the premiums is used for administration, marketing, insurance broker commissions, underwriting, and other overhead costs of the insurance carrier.[44]

The Candidates' Solutions

President Obama: The Affordable Care Act

Much like its focus on providing new options to consumers who must buy coverage on their own, the Affordable Care Act provides a number of remedies to the challenges faced by small businesses who want to offer health insurance to their employees.

Since 2010, the first year of the health reform law, small businesses with fewer than 25 employees and average wages of under $50,000 have been eligible for premium tax credits that cover 35 percent of the cost of premiums. President Obama has proposed increasing eligibility to firms with up to 50 employees.[45] Starting in 2014, the tax credits increase to 50 percent of premium costs through 2016 for plans purchased through small business exchanges, which will be open in each state.

The small business exchanges, also known as the Small Business Health Options Program, or SHOP, will be open to firms with up to 100 employees, although states can choose to limit participation to firms with up to 50 employees until 2016, when firms with up to 100 workers will be eligible. The SHOP exchanges will allow employers to let workers choose any qualified plan sold through the exchanges, either across multiple benefit levels or from selected levels (such as silver or gold). Conversely, employers may offer a more narrow choice of plans within or across benefit levels, or they may choose just one plan for their employees. SHOP exchanges will provide participating employers with a single monthly premium bill for all plans in which their employees are enrolled. The exchange would then facilitate payment—covering both the employer and employee contribution to the health plan premiums—to the health plans.

Governor Romney

Governor Romney would work to repeal the Affordable Care Act, along with the small business tax credits and the SHOP exchanges. In their place, he would encourage small businesses to form purchasing pools. He would leave it to states to create exchanges or other insurance coverage options for small businesses and consumers.

How the Candidates' Solutions Stack Up on Addressing the Challenges of Small Businesses

In the 2010 tax year, 170,000 small businesses claimed premium tax credits worth $468 million.[46] If President Obama is successful in increasing the size of small businesses that are eligible for the tax credits, more firms could potentially benefit. The SHOP exchanges are a potential means by which small businesses can realize lower premiums and greater choice of plans for their employees. But because employers can elect to buy coverage outside the exchanges, the success of the SHOP exchanges as effective purchasing pools will depend on their ability to offer high-value health plan options and lower premium and administrative costs for small employers.[47]

Governor Romney's proposal to repeal the law would increase costs for employers who are currently taking advantage of the premium tax credits. It would also mean that small employers in some states would continue to face denial of coverage and higher premiums based on the health of their workforces. Romney has proposed empowering small businesses to form purchasing pools, also known as multiple employer welfare arrangements (MEWAs) and association

health plans, but has not laid out a specific policy proposal. MEWAs, which exist in most states, enable small employers to band together through trade and other associations to share the administrative costs of providing health insurance and they are often able to avoid state insurance market regulations and benefit requirements.[48] This has the potential to lower premiums for employers with younger and healthier workers but raise them for employers with older workforces, which may continue to purchase coverage in the small-group market.[49] MEWAs have allowed many small employers to offer their workers coverage more cheaply, but some have been plagued by insolvency problems.[50]

6. Will the Candidates' Plans Improve Medicare?

The Problem

With the nation's large deficit and rising debt, reducing growth in federal health spending is a key component of the budget debate.[51] As the largest payer for health care, Medicare will spend in 2012 almost $600 billion for its more than 50 million beneficiaries, accounting for more than 20 percent of U.S. national health expenditures.[52] Like the rest of the health care system, Medicare faces rising health care costs: prior to enactment of the Affordable Care Act, total Medicare spending was projected to increase by 98 percent between 2008 and 2018. Under that scenario, the Medicare Hospital Insurance (Part A) Trust Fund, which pays for hospital and other facility-based services used by Medicare beneficiaries and is financed by an earmarked payroll tax, was projected to become insolvent by 2017.[53]

Medicare beneficiaries, who pay premiums and share in the costs of their care, are also affected by rising health care costs. A recent study found that total out-of-pocket expenditures in the last five years of life among Medicare beneficiaries averaged $38,688 for individuals and $51,030 for couples in which one spouse died, with expenses varying significantly by disease.[54] A report last year by the U.S. Census Bureau found that when family incomes were adjusted for out-of-pocket medical costs, the national poverty rate among adults 65 and over rose by more than seven percentage points, the biggest increase for any age group.[55]

The Candidates' Solutions

President Obama: The Affordable Care Act

The Affordable Care Act includes an extensive set of changes to the Medicare program, including provisions that are aimed at: 1) improving benefits, 2) reducing spending, 3) increasing revenues, and 4) improving quality of care.[56]

Benefit improvements in Medicare. Starting in 2010, the law began improving the cost protection that Medicare benefits provide by phasing out the coverage gap or "doughnut hole" in prescription drug coverage, covering preventive care services without cost-sharing, and introducing a free annual wellness visit. Starting in 2010, Medicare beneficiaries with Part D prescription drug coverage who spent enough to reach the doughnut hole ($2,830) automatically received $250 rebates. In 2011, beneficiaries who reached the coverage gap received a 50 percent discount on brand-name drugs. Additional discounts on brand-name and generic drugs will be phased in, so that the doughnut hole for all Part D enrollees will be closed by 2020. The Department of Health and Human Services estimates that more than 5 million Medicare beneficiaries have received just over $3 billion in rebates and discounts since 2010.[57] The agency estimates that about 32 million seniors have received one or more free preventive services, including the new annual wellness visit.[58]

Spending reductions in Medicare. The health reform law reduces the rate of growth in payments for most Medicare services other than physician and prescription drugs: hospital, skilled nursing, hospice, home health, and other services. The law also slows the rate of growth in payments to private Medicare Advantage plans. In an analysis of a bill introduced in the House of Representatives to repeal the Affordable Care Act, CBO estimated that repeal of these provisions would increase Medicare spending by $571 billion over 2013–2022.[59]

Revenue increases in Medicare. The Affordable Care Act increases the Medicare payroll tax by 0.9 percent for individuals with incomes over $200,000 or couples over $250,000. The law also added a new 3.8 percent "unearned income Medicare contribution" on income from interest, dividends, annuities, and other nonearnings sources for individuals with incomes over

$200,000 or couples over $250,000. CBO estimates that repeal of these provisions would reduce federal revenues by $318 billion over 2013–2022.[60] The law also includes a new fee for manufacturers and importers of brand-name prescription drugs.[61] CBO estimates that repealing this provision would reduce revenues by $34 billion over 2013–2022.

Provisions aimed at improving health care quality for Medicare beneficiaries. There are a substantial number of new initiatives in the Medicare and Medicaid programs to encourage changes in the way health care is delivered. These include financial incentives to reduce hospital readmissions and "shared savings" programs to encourage physicians and other providers to coordinate beneficiary care better. These provisions are discussed in the next section.

Effect of the law's Medicare provisions on spending. CBO has estimated that a repeal of the Affordable Care Act would increase Medicare program spending by $716 billion over the 10-year period 2013 to 2022.[62] The Medicare trustees also project that the estimated savings in the Medicare program from the Affordable Care Act will extend the solvency of Medicare's Hospital Insurance Trust Fund to 2024, compared with 2017 prior to the law's passage.[63] But the reduced program spending in Medicare also lowers overall federal spending, improving the federal budget outlook. In combination with all the other reform provisions, including new spending on insurance subsidies and new revenues, lower Medicare spending helps the Affordable Care Act, on net, reduce the federal deficit. In its analysis of the House bill to repeal the law, CBO estimates that deficits would increase by $109 billion over 2013–2022.

Governor Romney

Governor Romney has proposed repealing the Affordable Care Act, along with all its changes to the Medicare program. However, he has also proposed significant changes in how beneficiaries would be covered by Medicare. As chairman of the House budget committee, Romney's running mate, Rep. Paul Ryan, has also proposed similar changes to Medicare. Over time, Romney and Ryan propose reducing federal spending on Medicare by converting Medicare into a "defined contribution" benefit.[64] Under this approach, private insurers wishing to offer Medicare coverage would offer a bid for the year specifying the premium they would charge. Once all bids have been submitted, beneficiaries would have a choice between traditional Medicare and these private plans, using a "premium support" contribution from the government, adjusted for the beneficiary's income and health status.

Several versions of the premium support approach have been proposed in recent years.[65] In Ryan's most recent proposal, reflected in the Budget Resolution for 2013 passed by the House of Representatives in March 2012, individuals becoming eligible for Medicare beginning in 2023 would be given a choice of private plans competing with traditional Medicare in a newly created Medicare exchange.[66,67] In addition, the eligibility age would be increased gradually to 67 by 2034. Each beneficiary would be provided with a premium support subsidy equal to the premium charged by the second-least-expensive private plan available in their area, or to local per capita costs in traditional Medicare—whichever is less—adjusted for health and income. If a beneficiary chooses a costlier plan, he or she would be responsible for paying the difference between the premium support subsidy amount and the chosen plan's monthly premium. Conversely, if the beneficiary chooses the less-costly plan, a rebate for the difference would be provided. Private health plans participating in the exchange would be required both to cover at least the actuarial equivalent of the traditional Medicare benefit package and to offer coverage to all beneficiaries. If this competitive bidding model failed to rein in cost growth sufficiently, the per capita cost of the program would be limited to the rate of growth in the nation's gross domestic product, or GDP, plus 0.5 percentage points, starting in 2023.

How the Candidates' Solutions Stack Up on Medicare

President Obama's pledge to continue implementing the Affordable Care Act means that beneficiaries would continue to benefit from the phaseout of the prescription drug doughnut hole, eliminated cost-sharing for preventive services, and an annual wellness visit. The changes in spending and new revenues would reduce overall Medicare spending, which the Medicare trustees have projected to extend the solvency of Medicare's

Hospital Insurance (Part A) Trust Fund to 2024 from 2017.

Governor Romney's intent to repeal the law would restore the doughnut hole to Medicare's prescription drug benefit and cost-sharing for preventive care services and end the annual free wellness visit. Under CBO's estimates, repeal would also end the Medicare spending reductions and higher taxes and fees in the law, increasing net Medicare spending by $716 billion over 2013–2022. This higher Medicare spending would also deplete the Hospital Insurance Trust Fund more quickly, by 2016 rather than 2024.

CBO has estimated the impact on the federal budget of the most recent proposal for competitive bidding and premium support proposed by Representative Ryan in his role as chairman of the House budget committee.[68] Ryan's proposal, however, also includes the Medicare changes in the Affordable Care Act, including improved benefits as well as proposed spending reductions and revenue increases. CBO has not estimated Romney's proposed repeal of these provisions, which would increase Medicare spending by $716 billion over 2013–2022, coupled with his proposal for competitive bidding and premium support. But under Ryan's most recent proposal, CBO estimates that average inflation-adjusted spending for new enrollees in Medicare would rise over the next several decades, though at a much slower rate compared with that under current law. Under current law, average spending, in 2011 dollars, for a 66-year-old rises from $5,500 in 2011 to $8,600 in 2030, 56 percent more; under Ryan's proposal, it would rise to only $7,400, 35 percent more. In 2050, average spending for a 67-year-old would be, in 2011 dollars, $17,000 under current law and $11,100 under Ryan's proposal. By 2050, spending for new enrollees under Ryan's proposal would be 35 percent lower than under current law.

As just stated, however, the Romney campaign's pledge to repeal the Affordable Care Act and its Medicare provisions would increase average federal spending on Medicare. The Romney–Ryan approach would therefore place greater pressure to lower Medicare spending and likely increase out-of-pocket spending for beneficiaries if growth in premium support fails to keep pace with growth in health care costs.[69]

7. Will the Candidates' Plans Improve Health Care Quality and Slow Health Care Spending Growth?

The Problem

The cost of health care is a major cause of the growing numbers of people who are uninsured or underinsured, delaying needed care, and struggling with medical bills. While the annual rate of growth in U.S. health care spending slowed considerably over 2009–2010 to 3.9 percent, it continued to exceed growth in median family income over that period.[70] Cost growth, in turn, drives the cost of health insurance for both individuals and employers. A recent Commonwealth Fund study found that premiums in employer-based health plans climbed 62 percent over 2003–2010, but that those premiums bought less coverage: deductibles doubled at the same time.[71] Yet despite the millions of people who are uninsured or underinsured, the U.S. spends more per person on health care than other industrialized countries, all of which have universal coverage. In 2009, per capita health spending climbed to nearly $8,000, two-and-one-half times the median in 13 other advanced nations.[72]

Despite the high and rising level of spending in the U.S., health system performance lags behind many other countries.[73] Access to care, quality, patient experiences, and health outcomes clearly are not what they should be.[74] Both abroad and within areas of this country, there are numerous examples of excellence in health system performance, demonstrating that substantial improvement is feasible.

The Candidates' Solutions

President Obama: The Affordable Care Act

The Affordable Care Act seeks to improve quality of care and lower growth in health spending through reforms focused on insurers and providers. On the insurance side, requiring everyone to have health insurance by 2014 will pool risks and costs much more broadly than they are today by bringing in younger and healthier people into insurance markets and spreading administrative costs across much larger groups. The Congressional Budget Office estimates that young and healthier people in the individual market and exchanges will reduce premiums by 7 percent to 10 percent.[75] CBO

estimates that premiums would decline by an additional 7 percent to 10 percent because of lower administrative costs and greater economies of scale in the provision of insurance.

The law also sets explicit controls on insurance premiums. This August, health plans in the large-employer group market that spent less than 85 percent of their premiums on medical care and quality improvement activities, as opposed to administration and profits, along with plans in the small-employer group and individual markets that spent less than 80 percent on the same, paid more than $1 billion in rebates to policy holders. Other carriers reduced their premiums to meet the new limits. In addition, since July 2011, any insurance carrier that increases its premiums by 10 percent or more in the individual or small-employer group insurance markets has to justify the increase to state officials and the U.S. Department of Health and Human Services. According to HHS, premium review saved consumers an estimated $1 billion in 2012.[76] Starting in 2014, states can recommend that health plans be excluded from participation in the insurance exchanges if they have demonstrated a pattern of excessive or unjustified premium increases.

The reform law contains numerous provisions to support systemwide changes to the way that care is delivered and paid for in the U.S. These changes are intended to encourage providers to deliver higher-quality, more-effective care to patients, rather than rewarding providers solely for the volume and intensity of services they deliver, regardless of their actual value to patients. Although many of those provisions are focused on Medicare as well as Medicaid and the Children's Health Insurance Program (CHIP), there also are provisions that call for multipayer initiatives encompassing not only the public but also the private sector. Moreover, Medicare, as the largest payer in the health system, can serve as a platform for developing and implementing payment and system reforms that can be applied throughout the health system. Medicare can also partner with other public programs and private payers to improve system performance.

Resources to promote system improvement. The Affordable Care Act contains significant new resources and tools designed to facilitate the development and spread of promising models of health care delivery and payment that emphasize providing high-quality, coordinated, patient-centered care (Exhibit 12).

The *Center for Medicare and Medicaid Innovation (CMMI)* was established to identify and evaluate new payment and service delivery models for Medicare, Medicaid, and CHIP while enhancing quality of

Exhibit 12. System Improvement Provisions of the Affordable Care Act

Supporting primary care, prevention, and wellness	Primary care 10% bonus for five years; Medicaid payment rates to primary care physicians no less than 100% of Medicare rates in 2013 and 2014; annual wellness visit and/or health risk assessment for Medicare beneficiaries; preventive services without cost-sharing; local and employer wellness programs; medical home initiatives
Payment reforms to encourage and support improved system performance	Value-based purchasing programs; reduced payment for hospital- acquired conditions and potentially preventable readmissions; bundled payment for acute and postacute care
Accountable care organizations	Accountable care organizations to share savings in Medicare
Controlling health spending	Independent Payment Advisory Board recommendations to meet Medicare expenditure target as well as total system spending nonbinding recommendations; productivity improvement update factor
Resources to promote system improvement	Center for Medicare and Medicaid Innovation; Patient-Centered Outcomes Research Institute; Medicare–Medicaid Coordination Office
Quality improvement and public reporting	Directs the U.S. Department of Health and Human Services to develop national quality strategy, public reporting
Accelerating the adoption of health information technology	Incentives to providers that encourage them to adopt and meaningfully use health information technology
Medicare private plan competition	Levels the playing field between Medicare Advantage and traditional Medicare fee-for-service plans

Source: Commonwealth Fund analysis.

care for beneficiaries (Exhibit 13). The authorization under the law provides $10 billion in direct funding in fiscal years 2011 through 2019 to cover the costs of development and evaluation, and it allows the HHS secretary to expand successful innovations if they reduce costs and/or improve outcomes. Medicare also is provided with authority to partner with both state-led and private payment initiatives. When health reform was enacted, CBO estimated that creation of the CMMI would save $1.3 billion between 2010 and 2019.[77]

The *Patient-Centered Outcomes Research Institute (PCORI)* is a public–private partnership created to encourage research on diagnosis and treatment options and to accelerate patient-centered outcomes research and methodological research.[78] PCORI will be funded by appropriations from general fund revenues and fees assessed on Medicare, private health insurance, and self-insured plans starting in 2013. The institute is expected to receive an estimated $3.5 billion to fund patient-centered outcomes research through 2019, the date through which its operations are authorized.[79] In April

Exhibit 13. Overview of Center for Medicare and Medicaid Innovation–Sponsored Initiatives

Bundled Payments for Care Improvement. Tests four different payment models to encourage improved care coordination and efficiency related to hospital admissions. Currently selecting participants.
Pioneer ACO Model. Tests advanced ACO models. 32 organizations are participating.
ACO Advance Payment Model. Tests whether advance payments will assist participation in the Medicare ACO programs for physician-led and rural organizations with limited access to start-up capital. 20 organizations are currently participating.
Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration. Supports 500 FQHCs' transformation to medical homes through $6 per member per month payment for each eligible Medicare beneficiary.
Comprehensive Primary Care Initiative. Public and private payer collaborative to strengthen primary care, involving risk-adjusted, monthly care management fees, as well shared savings payments. 7 states and 500 primary care practices are currently participating.
Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents. Seeks to improve quality of care for people in nursing facilities by reducing preventable inpatient hospitalizations. Currently selecting participants.
Partnership for Patients. Nationwide public–private partnership to support safer care and more effective transitions of patients from hospitals to other settings. $218 million was awarded to 26 organizations to be Hospital Engagement Networks, which help identify and spread solutions already working to reduce health care–acquired conditions. An additional $500 million is available for models improving care transitions and reducing readmissions for high-risk Medicare beneficiaries. Already, 47 participants have been selected for that program.
Independence at Home Demonstration. Tests effectiveness of delivering comprehensive primary care at home, focusing on patients with multiple chronic conditions. 15 independent practices and 3 consortia participating.
Medicaid Emergency Psychiatric Demonstration. Tests whether Medicaid can support higher-quality care at a lower total cost by reimbursing private psychiatric hospitals for certain psychiatric services for which Medicaid reimbursement has historically been unavailable. 11 states and D.C. are participating.
Medicaid Incentives for the Prevention of Chronic Diseases. Provides incentives to Medicaid beneficiaries participating in prevention programs and demonstrate changes in health risk. 10 states are participating.
Financial Alignment Initiative. Aligns financial incentives of Medicare and Medicaid to provide Medicare–Medicaid enrollees with a better care experience. This opportunity is open to all states. Currently, one state is participating.
State Innovation Models Initiative. A competitive funding opportunity for states to design and test multipayer payment and delivery models that deliver high-quality health care and improve health system performance. Up to $275 million will be made available for up to 30 grants.
Health Care Innovation Awards. Provides grants up to $30 million to participants who are implementing innovative ideas to deliver better health, improved care, and lower costs. 107 grants totaling $894 were awarded. Nearly $2 billion in savings is expected over three years from these initiatives.
Strong Start for Mothers and Newborns. Supports reducing the risk of significant complications and long-term health problems for both expectant mothers and newborns.
Graduate Nurse Education Demonstration. Provides hospitals with funds for clinical training of advanced practice registered nursing (APRN) students. 5 hospitals are participating.
Innovation Advisors Program. Creates a network of delivery system reform experts. 73 advisors have been selected.

2012, PCORI approved 50 pilot projects, totaling $30 million over two years, to help determine the best ways to engage patients in both research and dissemination of findings.

The *Medicare–Medicaid Coordination Office (MMCO)* was created by the Affordable Care Act to increase coordination between Medicare and Medicaid for the 9 million low-income aged and disabled beneficiaries who are eligible for both and who account for a disproportionate share of spending in the two programs. Compared with other beneficiaries, these "dual eligibles" are more likely to be disabled and to have cognitive impairment and multiple chronic conditions.[80] As of September 2012, MMCO has initiated demonstrations to integrate care for these individuals in 15 states, supported efforts to reduce avoidable hospitalizations among nursing home residents, and acted to provide data and technical assistance to all states to improve care for the dual-eligible population.[81]

Payment reforms to encourage and support improved system performance. The Affordable Care Act includes several payment reform initiatives to promote and support changes in the way health care is organized and delivered.[82] The range of payment reforms included in the law reflect the diversity of the health system—different configurations of providers and payers and populations to be served—as well as variation in the degree of readiness of providers across the country to participate in alternative reimbursement arrangements. The Affordable Care Act specifically mentions several new models of health care delivery that are to be developed, tested, and implemented more broadly if they are found to improve care and reduce costs. While most of the payment reforms in the law are primarily focused on Medicare, they build on—and are intended to be combined with—similar efforts occurring in the private sector.

Value-based purchasing. In October 2012, Medicare began a value-based purchasing program that links a portion of the payments hospitals receive directly to the quality of their care.[83] Hospitals will be at risk for a portion of their regular Medicare payments (starting at 0.5% in fiscal year 2013 and reaching 2.0% by fiscal year 2017).[84] Depending on how hospitals perform on a range of quality measures, they may be able to earn incentive payments that are potentially even greater than their regular reimbursement for services rendered. Initial performance measures will cover clinical processes of care for cardiac, surgical, and pneumonia conditions, as well as patient survey data. Over time, measures of outcomes (e.g., mortality) and efficiency (e.g., per-beneficiary spending) will also be included. The law also mandates efforts to develop Medicare value-based purchasing programs for physician services, skilled nursing facilities, home health services, and ambulatory care center services, with some of the performance measures for these programs already being collected.[85] Although these programs apply only to Medicare payments, the potential benefits of the resulting shift of emphasis from volume to value of services should accrue to patients, payers, and providers throughout the health system.

Reduced payments for hospital-acquired conditions. The Affordable Care Act also includes provisions to discourage adverse medical outcomes related to hospital stays. Prior to the reform law, Medicare had stopped paying hospitals for services related to certain hospital-acquired conditions, and the law strengthens this effort. Beginning in fiscal year 2015, hospitals in the top quartile of rates of designated hospital-acquired conditions will have their Medicare payments for all patient discharges reduced by 1.0 percent. The law also reduces Medicare payments, starting in fiscal year 2013, for hospitals that have excess readmission rates related to heart attack, heart failure, and pneumonia; additional conditions may be added in future years. As of July 2012, the Medicaid program is also prohibited from paying for certain hospital-acquired conditions.

Supporting primary care. The patient-centered medical home is an approach to providing comprehensive primary care that facilitates partnerships between individual patients and their physicians.[86] The medical home model recognizes the key role of primary care in achieving both better patient outcomes and lower health care costs.[87] It also focuses care on the needs of patients and their families and provides a means for helping them navigate the complex health system. The health reform law includes initiatives for developing and assessing different payment structures for the medical home model in Medicare, encourages the development

of health home models in state Medicaid programs, and provides for the establishment of multipayer partnerships to coordinate efforts to support the medical home more broadly.

The law also provides primary care practitioners with a 10 percent Medicare bonus payment from 2011 through 2015.[88] To qualify for the bonus, a physician must have a specialty designation of internal, family, pediatric, or geriatric medicine, and at least 60 percent of their Medicare billings (i.e., allowable charges) must be for the designated primary care services on which the bonus payment is based. Clinical nurse specialists, nurse practitioners, and physician assistants are also eligible. In 2011, payments were made to over 150,000 providers and exceeded $560 million.[89]

In recognition of the key role Medicaid plays in the coverage expansion and the fact that health care providers are usually reimbursed below both Medicare and commercial payer rates for Medicaid services, the Affordable Care Act also includes several provisions to address the way Medicaid providers are paid and how care is delivered. Since many of the newly insured will have been previously uninsured, there is an important opportunity to connect people—for what may be the first time for many—to the benefits of primary and preventive care. In 2013 and 2014, Medicaid services provided by family practice physicians, pediatricians, and other family practice providers will be reimbursed at the higher Medicare rate. Medicaid rates are set at the state level and vary across the country, but on average they were 72 percent of the Medicare rate, as of 2008.[90] The rate increase for primary care providers is projected to amount to $5.5 billion in 2013 and $5.7 billion in 2014.[91]

Creating accountable care organizations (ACOs). The first ACOs were approved in 2012 for participation in the new Medicare Shared Savings Program established under the law. ACOs are groups of providers that agree to take joint responsibility for the care of the patients they treat and to be held accountable for the quality, outcomes, and costs of care.[92] The ACO is built around a core of primary care, but it is explicitly responsible for providing, or arranging to provide, all the care that patients need. In the Shared Savings Program, ACOs can receive additional payments if they keep their costs below a predetermined target, subject to providing high-quality care according to a specified set of measures.

Consistent with the notion of offering an array of approaches to move the health system toward more coordinated, effective, and efficient care, several alternative payment options are available to ACOs. At the most basic level, ACO providers continue to receive their traditional fee-for-service payments and are eligible for applicable shared-savings payments, without being at risk for costs in excess of spending targets. A more advanced option requires providers to be responsible for any excess costs their patients incur, as well as sharing in any savings; in return for assuming risk for excess costs, those ACOs can retain a greater proportion of any savings they achieve. Under a Pioneer ACO initiative conducted by the CMMI, payment options are available that allow providers to receive part of their payments on a per-patient basis.

As of July 2012, more than 150 ACOs were in the Shared Savings Program or an alternative payment model. CBO estimated that the Medicare Shared Savings Program alone would reduce Medicare spending by $4.9 billion in the first nine years (from 2010 to 2019).[93]

Encouraging coordinated care through bundled payment. A new CMMI initiative is testing several models of "bundled payment," which is a single payment made for an entire episode of care. The payment covers a defined set of services delivered by designated providers in specified health care settings, usually delivered within a certain timeframe, related to treating a patient's medical condition or performing a major surgical procedure. The goal of bundled payment is to encourage hospitals, physicians, and other providers to work together to improve transitions in care, such as a patient's move from a hospital to home care, thereby reducing the need for rehospitalization and improving health outcomes. Participants will have considerable flexibility in defining the conditions and identifying partnering providers for bundled payments, reflecting the various approaches to bundling that are currently being used.[94]

Accelerating the adoption of health information technology. Health information technology (IT), ranging from electronic health records to automated physician

alert systems, has the potential to improve the health care patients receive while yielding long-term cost savings for the health system.[95] The Heath Information Technology for Economic and Clinical Health (HITECH) Act, enacted as part of the American Recovery and Reinvestment Act of 2009, provided up to $27 billion in incentives to encourage providers to adopt and use health IT to improve care, increase their ability to coordinate with one another, and reduce the cost of care by reducing duplicative testing and other inefficiencies.[96] In addition, the Office of the National Coordinator for Health Information Technology has implemented several programs to strengthen the nation's health IT infrastructure and encourage its meaningful use in improving care. By the end of September 2011, more than 100,000 eligible health care providers—21 percent of all providers—had registered for those "meaningful use" payments. Moreover, the proportion of U.S. physicians reporting that they were using at least a basic electronic health record had increased to 34 percent in 2011, up from 22 percent in 2009.[97]

Governor Romney

The Romney campaign has pledged to repeal the Affordable Care Act, including all the provisions described above, on the grounds that it represents too much federal government interference in health care markets. Instead, it has proposed a set of policies that would shift more control of health care to private insurers and to states, with incentives to make consumers more cost-conscious in their decisions on health care coverage and health care purchases. These would include limiting the federal government's liability for health care costs by converting Medicare from a defined benefit to a defined contribution program with premium supports, as described above. Romney would replace federal matching payments to states for their Medicaid programs with block grants that would rise at a predetermined rate each year; he also would provide states with greater flexibility in and responsibility for administering their Medicaid programs.

Romney would cap noneconomic damages in medical malpractice lawsuits to reduce both the cost of liability insurance for providers and the incentive to provide excess services as a protection against potential lawsuits. He would also offer innovation grants to explore non-litigation alternatives to dispute resolution. In addition, he would facilitate the interoperability of health information technology. He also would promote alternatives to the current fee-for-service payment system, though he has not specified how he would do this.

How the Candidates' Solutions Stack Up on Quality Improvement and Cost Containment

The Congressional Budget Office estimates that repealing the Affordable Care Act will increase the federal deficit by $109 billion between 2013 and 2022 (Exhibit 14).[98] The loss of spending reductions in the law's payment and system reforms as well as new revenues would offset savings from repeal of the coverage expansions.

President Obama's continued implementation of the law would move forward, including changes in how care is organized, delivered, and paid for. Many of the law's provisions are focused on Medicare, in addition to Medicaid and the Children's Health Insurance Program, but multipayer initiatives that include both the public and private sectors are encouraged as well. Models like the patient-centered medical home and the accountable care organization, both of which emphasize the role of primary care and the need to coordinate care across providers and settings, are being developed to improve care and stabilize costs, and the meaningful use of health information technology is seen as a foundation for these models. David Cutler, Karen Davis, and Kristof Stremikis estimate greater savings than CBO does from the law's delivery system reforms—$406 billion by 2019—and consequently a much greater net decrease in the federal deficit of $400 billon by that same year.[99]

Romney's pledge to repeal the Affordable Care Act would end all of the law's delivery system reforms, including those that are already under way. He would pursue policies that focus on the states as the drivers of reform and limit federal regulation, looking to the free market as the primary source of innovations in health care delivery. As President Obama does, Romney recognizes that the interoperability of health information technology is an important component of health care improvement. But his proposed repeal of

Exhibit 14. Estimated Budgetary Effects of Repealing the Affordable Care Act, 2013–2022

	July 2012 Congressional Budget Office estimate
Net change from coverage provisions	**–$1,171**
Coverage provisions	–$1,677
Revenues and wage effects	$506
Net change from payment and system reforms	**$711**
Reductions in annual updates to Medicare provider payment rates	$415
Medicare Advantage reform	$156
Provider payment changes and other provisions	$140
Net change in noncoverage revenues	**$569**
Manufacturer and insurer fees	–$165
New Medicare taxes on high-income earners	–$318
Other provisions	–$87
Total net impact on federal deficit, 2013–2022	**$109**

Notes: Totals do not reflect net impact on deficit because of rounding.
Source: D. Elmendorf, "Letter to the Honorable John Boehner" (Washington, D.C.: Congressional Budget Office, July 24, 2012).

the Affordable Care Act would eliminate many of its incentives for health IT development in this area.

Romney, like Obama, also favors promoting alternatives to the inefficient and costly fee-for-service payment system, but the specific means he would employ to accomplish that goal are unclear.

Romney has also proposed to slow spending growth by capping noneconomic damages in medical malpractice lawsuits. A CBO analysis of capping noneconomic damages in medical malpractice lawsuits found that such limits could lower malpractice insurance premiums and provide some small savings in health care costs, about 0.5 percent or less of total health spending.[100]

Many of the initiatives supported by the Affordable Care Act already are under way. Value-based purchasing programs in Medicare are being implemented; the Medicare Shared Savings Program and related initiatives now include more than 150 participants; the medical home model is being developed in both Medicare and Medicaid; and electronic health records are being used in thousands of physician practices and hospitals across the country. In addition, state Medicaid programs have been working to encourage the delivery of better coordinated care to their beneficiaries, with initiatives in place in Vermont, Massachusetts, North Carolina, Montana, Missouri, Illinois, Indiana, and many other states.[101]

CONCLUSION

On each of the seven criteria used in this analysis to evaluate the candidates' health care platforms, President Obama's plan to fully implement the Affordable Care Act would likely outperform Governor Romney's plan to repeal the law and replace it with fewer federal requirements for insurance markets and reduced funding for the Medicaid and Medicare programs. This conclusion is driven in part by the considerable detail available in the health reform law and the new guidance and regulations issued by the U.S. Department of Health and Human Services to implement its provisions, compared with Romney's far less detailed proposals to replace the law.

The Affordable Care Act substantially increases and improves health insurance coverage in private insurance markets and public insurance programs for Americans in every income and age group. It also provides new incentives for improving health care quality and lowering the rate of growth in health spending. Fully two-and-a-half years after its passage and with many of its provisions already in place, the health reform law is already interwoven into the nation's regulatory and industrial landscape. In 15 months, the law's major insurance coverage provisions will be rolled out, and more than 30 million Americans will gain subsidized coverage over the next decade.

Of course, raising our health system's level of performance to achieve sustainable, near-universal access to affordable health insurance and health care, improved quality and patient-centeredness, greater accountability for both health outcomes and treatment costs, and better overall population health will require much more than the efforts of the federal government. Regardless of the outcome of the election, it will be critical for state and federal policymakers, regulators, businesses, consumers, and other key stakeholders to work together to achieve the vision of high-quality, safe health care at a price that everyone in America can afford.

Methodology

The analysis of the Affordable Care Act and Governor Romney's health care proposals was conducted by Jonathan Gruber, professor of economics at Massachusetts Institute of Technology. It is based on the Gruber Microsimulation Model (GMSIM), which allows the user to input a set of policy parameters and output the impact of these policies on costs (both public- and private-sector) and on the distribution of insurance coverage. The modeling approach is the type of microsimulation modeling that is used by the U.S. Treasury Department, the Congressional Budget Office (CBO), and other government entities. This approach consists of drawing on best available evidence in the health economics literature to model how individuals and firms will respond to changes in the insurance environment that are induced by changes in government policy. The U.S. Census Bureau's Current Population Survey (CPS) is the primary data source in the GMSIM. The CPS includes data on family demographics, tax rates, and insurance status. The baseline dataset is the 2005–2007 Current Population Surveys (CPS), which provide the individual-level data on about 40,000 nonelderly individuals and household units. The 2005 CPS is augmented with the 2006 and 2007 CPS to obtain a larger sample size for greater precision at the state level, and state averages are then updated to 2011 to reflect current conditions. Income and demographic measures are updated with the most recently available CPS data. The CPS is augmented by health expenditure and premium data from the U.S. Agency for Healthcare Research and Quality's Medical Expenditure Panel Survey (MEPS), as well as by data from the Kaiser Family Foundation on public program expenditures and eligibility. The GMSIM is calibrated to estimate the total impact of alternative policies at the national level. GMSIM analyses for individual states may differ from the findings in this report when state-specific information from a source available only in a state is included, such as specific information on state pricing in the nongroup insurance market.

To evaluate the effects of the candidates' proposals on health insurance coverage, Jonathan Gruber modeled three policy scenarios: 1) the baseline, or what insurance coverage would be if the Affordable Care Act had not been implemented; 2) the Affordable Care Act fully implemented with all states participating in the Medicaid expansion; and 3) Governor Romney's proposals to provide federal block grants to states for their Medicaid programs and provide the same tax advantages to people who buy coverage on their own as those who get insurance through an employer. While the details of Governor Romney's proposals have not been specified, a set of assumptions was made for the report based on similar proposals advanced in the past. For the Medicaid block-grant proposal, it was assumed that: 1) block grants to states would grow at the rate of growth in the consumer price index plus 1 percent;* 2) states would match this lower rate of spending growth in their share of Medicaid spending; 3) states would meet these new spending limits through cuts in Medicaid costs, such as lower provider payments or reduced benefits (50%) and through reduced eligibility for the program (50%); and 4) states would maintain existing eligibility for the elderly and disabled in the Medicaid program, so that any eligibility cuts needed to meet spending targets will come from reduced eligibility of nonelderly, nondisabled program enrollees. For Romney's proposal to give tax advantages to individually purchased plans, Gruber modeled a scenario where people who purchase health insurance in the individual market could deduct their premiums from their income on an "above-the-line" basis; i.e., a deduction available to all, not just those who itemize their taxes.

In an earlier version of this report, it was incorrectly stated that block grants would grow at the rate of population growth plus 1 percent.

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