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THE DEBATE

HEALTH ISSUES IN THE 2000 PRESIDENTIAL ELECTION

A Comparison of Proposals

Prepared by Health Policy Alternatives, Inc.
for a joint project of the
League of Women Voters
Education Fund and the
Henry J. Kaiser Family Foundation

This guide was developed by the League of Women Voters Education Fund and the Henry J. Kaiser Family Foundation as part of a nonpartisan public education initiative to inform citizens, stimulate dialogue, and give the public a greater voice in the health care debates during the 2000 elections.

The League of Women Voters Education Fund encourages informed and active participation of citizens in government and works to increase understanding of major public policy issues.

The Henry J. Kaiser Family Foundation, based in Menlo Park, California, is a nonprofit, independent national health care philanthropy and is not associated with Kaiser Permanente or Kaiser Industries.

JOIN THE DEBATE

Dear Reader:

Health care has emerged as one of the top issues in the upcoming presidential election. The candidates have staked out positions on a range of challenges—from expanding coverage for the uninsured to providing prescription drug coverage to seniors. As the campaign season heats up with the barrage of sound bites, advertisements and genuine policy differences, it is sometimes difficult to gain a clear understanding of where the candidates stand on health issues and how they differ on these important, complex and controversial topics.

To educate and engage the public on key health policy issues, the League of Women Voters Education Fund and the Henry J. Kaiser Family Foundation have joined in a nonpartisan public education initiative. Earlier this year, we released *Join the Debate: Your Guide to Health Issues in the 2000 Election*, a report that provides basic facts about major health policy topics.

This new report, *Health Issues in the 2000 Presidential Election: A Comparison of Proposals*, follows up the *Join the Debate* report by presenting basic, neutral information to help readers compare the proposals of the leading candidates, Gore-Lieberman and Bush-Cheney, in five areas of health care, including:

- Health coverage for the uninsured
- Managed care and patients' rights
- Medicare reform
- Prescription drug coverage for seniors
- Long-term care

Prepared by an independent team of researchers and reviewed for accuracy by both campaigns, this report provides a brief overview of each of these five topics, describes the candidates' general approach to each issue, and outlines policy proposals. In conjunction with *Join the Debate*, we hope this report helps you make a more informed choice when you cast your vote.

Sincerely,

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HEALTH COVERAGE FOR THE UNINSURED

Today: Most Americans obtain health insurance through employer-sponsored health plans, Medicare, or Medicaid. However, nearly 43 million are uninsured, many of whom face problems in getting and paying for medical care. Most of the uninsured are from families with at least one full-time worker. In 1999, almost seven in ten uninsured Americans had family incomes below about $50,000.

To expand health insurance coverage to low-income children, the State Children's Health Insurance Program (SCHIP) was enacted in 1997. SCHIP provides federal matching funds under a block grant to states to cover children in families with incomes up to roughly $34,000 for a family of four through expanded state Medicaid or alternative programs. Existing federal tax law provides for subsidies for employer-sponsored health insurance and for some individuals whose out-of-pocket medical expenses consume a significant share of their taxable income.

In addition, there are other federal initiatives that help some people pay for health care. Medical savings accounts (MSAs), available on a limited basis, are one way to pay for medical expenses with dollars that are not taxed. Additionally, many larger employers offer their employees the option of setting aside a fixed amount of tax-free dollars each year that would otherwise be provided as taxable salary to use for out-of-pocket health care and certain other health-related expenses. These are called flexible spending arrangements (FSAs). Employees forfeit whatever dollars are unused at the end of the year.

Both candidates have proposed initiatives to reduce the number of uninsured Americans or otherwise help people pay for medical care. They differ, however, in the extent to which they would use federal tax incentives (such as deductions and credits) to encourage individuals and small businesses to buy insurance coverage. They also differ in their support of public program expansions (for example, SCHIP, Medicaid, or Medicare). Both candidates favor increasing the funding for safety net providers—certain hospitals and clinics (such as community health centers) that deliver direct health care services to the uninsured.

HEALTH COVERAGE FOR THE UNINSURED

Comparison of Candidate Proposals — September 2000

GORE-LIEBERMAN	BUSH-CHENEY
General Approach	
Expands health insurance coverage under existing public programs, like SCHIP and Medicare. Provides tax credits to help people buy public and private insurance. Increases funding for safety net providers such as teaching hospitals and community health centers.	Provides tax credits to help people buy private insurance. Expands MSAs. Increases funding for safety net providers such as teaching hospitals and community health centers. Relaxes federal SCHIP rules to give states greater flexibility in covering children under SCHIP.
Coverage Under Public Programs	
• Expands SCHIP to children in families with incomes up to about $42,000 for a family of four. Gives more money to states meeting enrollment targets and reduces federal matching payments to states that do not. • Allows families with incomes above about $42,000 for a family of four that are not eligible for employer coverage to buy SCHIP or Medicaid coverage for their uninsured children. Gives families new federal tax credits to help pay the premiums for their SCHIP/Medicaid coverage. • Extends SCHIP to low-income parents of children enrolled in Medicaid or SCHIP. • Allows early retirees to buy into Medicare and provides a 25% tax credit to help pay premiums. • Allows disabled individuals to keep Medicare or Medicaid when they return to work.	Provides for increasing the number of covered children by relaxing the federal rules with which states must comply to get matching funds under SCHIP.
Tax-Based Incentives to Expand Coverage	
• Provides a 25% refundable tax credit for health insurance premiums for uninsured persons who buy individual insurance, SCHIP/Medicaid, or in the case of early retirees, Medicare or COBRA. [By making a tax credit refundable, people who would otherwise not have enough taxable income could still get the credit.] • Provides small businesses with a 25% premium tax credit for each employee if the business joins a health insurance purchasing coalition. [Coalitions try to reduce the cost of health insurance for their members by pooling many small employers into a single, large purchasing group.]	• Provides families a refundable tax credit of up to $2,000 ($1,000 for individuals) to help them buy health insurance if they do not qualify for government assistance or employer coverage. Full tax credit is available to families with income up to $30,000 ($15,000 for individuals). The tax credit phases out for those with incomes between $30,000 and $60,000 ($15,000 and $45,000 for individuals). • Eases MSA enrollment restrictions and eliminates MSA time limits. • Allows up to $500 in an FSA to be carried over to the next year.
Small Employer Coverage	
Encourages the establishment of small business coalitions by providing financial assistance to help them get off the ground.	Allows small businesses to purchase health plans from multistate trade associations, such as the Chamber of Commerce.
Safety Net Providers	
Increases funding for safety net providers, such as teaching hospitals and community health centers.	Increases funding for safety net providers, such as teaching hospitals and community health centers.

MANAGED CARE AND PATIENTS' RIGHTS

Today: Managed care and patients' rights have been widely debated during the past year, prompting discussion on a range of proposals in Congress. Managed care plans use various mechanisms to ensure that enrollees get the appropriate type and quantity of health care, and research has found that the quality of care is comparable to that of fee-for-service. But as plan enrollment has grown, so too have concerns about timely access to quality services. Dissatisfaction with aspects of managed care has led to calls for new laws to protect consumers. While most states have enacted at least some protections, these laws do not apply to some 48 million people who are covered by self-insured plans, where employers act as insurers themselves rather than buy insurance from an insurance company. This limited scope is because such plans are exempt from state law.

Though both houses of Congress have passed patient protection legislation, they have been unable to reconcile the differences between the bills. The House plan would extend federal patient protections to almost all of the insured under age 65 (about 161 million Americans). The Senate plan, by contrast, would apply many of the protections only to those in self-insured plans. Also, the House bill would allow patients to sue their health plans for actions that may harm patients, such as delays or denials of medical care; the Senate bill would not. Opponents of federal patients' rights legislation, particularly those who are against giving patients the right to sue their health plans, argue that the new laws would drive up health insurance premiums, leading some to drop their coverage and increasing the number of uninsured.

Both candidates support the passage of federal patients' rights legislation. But they differ on whether federal laws should be able to override existing state laws. They also differ on the details of the various patient protection provisions.

MANAGED CARE AND PATIENT'S RIGHTS

Comparison of Candidate Proposals — September 2000

GORE-LIEBERMAN	BUSH-CHENEY
General Approach	
Supports the House-passed version of the Patients' Bill of Rights and the application of similar patient protections to all insured Americans, including enrollees in public programs like Medicare and Medicaid.	Supports patient protections similar to the provisions in the House-passed bill. Supports expansion of patient protections at the federal level so long as they do not override state laws already on the books.
People Covered by Patient Protections	
All insured Americans.	Not stated, but supports expansion of federal laws provided they do not override state laws.
Right to Independent Appeal of a Health Plan's Decision	
Supports giving patients the right to a fair appeal by an independent entity if they disagree with a decision of their health plan.	Supports giving patients the right to a fair appeal by an independent entity if they disagree with a decision of their health plan.
Right to Sue One's Health Plan for Poor Quality of Care	
Supports giving enrollees the right to sue for compensatory and punitive damages for actions by health plans that harm patients, such as delays or denials of medical care. [Compensatory and punitive damages are monetary awards for potential consequences of delayed or poor quality care.]	Supports giving enrollees the right to sue their health plans for compensatory and punitive damages for actions by health plans that harm patients, such as delays or denials of medical care.
Access to Medical Specialists	
Supports ensuring appropriate access to specialists.	Supports ensuring appropriate access to specialists.
Access to Emergency Room Services	
Supports guaranteed coverage of emergency room care in emergency situations.	Supports guaranteed coverage of emergency room care in emergency situations.
Privacy of Medical Information	
Supports strong medical privacy protections and protection from discrimination based on genetic information.	No stated position.

MEDICARE REFORM

Today: The Medicare program provides health coverage to Americans 65 and older and to certain younger people with permanent disabilities. The traditional, fee-for-service Medicare program consists of two parts (Part A and Part B), which together cover most health care services, with the notable exception of outpatient prescription drugs. Coverage for preventive services is limited. There is no cap on the amount an individual might have to spend out-of-pocket in a year for deductibles and coinsurance.

While most people on Medicare are covered under the traditional fee-for-service program, beneficiaries also have the option of receiving their Medicare services by enrolling in an HMO or other private plan, under what is known as the Medicare + Choice program. Medicare + Choice plans provide Part A and B services to enrollees, and often provide additional benefits.

Workers pay taxes (collected in the Medicare Trust Fund) to finance Medicare Part A benefits for the current Medicare population, expecting that they or their spouses will have similar benefits when they retire. Medicare Part B is financed by general tax dollars and premiums paid by beneficiaries.

Medicare is facing a financing challenge in the future as the beneficiary population swells with the retirement of the Baby Boom generation and the number of younger workers paying taxes to support the program shrinks.

Both candidates advocate expanding Medicare benefits and changing the program to meet these challenges. Their proposals differ in how to structure the program and in the respective roles the government and the private sector should play in providing coverage to beneficiaries.

MEDICARE REFORM

Comparison of Candidate Proposals — September 2000

GORE-LIEBERMAN	BUSH-CHENEY
General Approach	
• Maintains Medicare's existing structure and adds a voluntary drug benefit [see page 9]. Gives the government more authority to control costs by, for example, permitting it to contract with certain doctors and hospitals that would care for seniors at lower costs. • Expands preventive benefits covered by Medicare. • Increases competition between traditional Medicare and Medicare + Choice plans by giving beneficiaries financial incentives to choose lower-cost plans. • Encourages stability in the Medicare + Choice program by requiring two-year contracts and other reforms.	• Restructures Medicare so that it would look more like the health plan for federal employees. Each year, beneficiaries would choose from a menu of health plans that offer the basic benefits covered by Medicare and a variety of additional benefits, including prescription drugs. (Effective 2004.) • In the years prior to restructuring the Medicare program (2001–2004), gives grant money to the states to provide prescription drug coverage to low-income people on Medicare and to beneficiaries with drug expenses over $6,000, regardless of income [see page 9].
Benefits	
• Establishes a new Part D of Medicare, which would provide standard subsidized outpatient prescription drug benefits (including coverage for catastrophic drug expenses). Beneficiaries would pay a uniform, monthly premium for this coverage. • Expands Medicare Part B coverage for preventive services. • Requires the Part B deductible (now $100) to rise with inflation.	• Offers Medicare beneficiaries the option of obtaining subsidized outpatient prescription drug benefits and protection against catastrophic medical expenses (for example, expenses exceeding $6,000 a year) through enrollment in a Medicare-approved private health plan or a government-sponsored plan. Monthly premiums would vary, depending on the plan selected. • Improves Medicare coverage for new technologies.
Future Financing	
• Changes federal budgeting rules so that any surplus in the Medicare Part A Trust Fund cannot be used to finance other government spending in order to balance the federal budget (sometimes called the "Medicare lock-box"). • Dedicates part of the federal budget surplus to improve Medicare's long-term financial status.	• Establishes a unified trust fund that combines Medicare Part A and Part B. • Opposes any increase in the Medicare Part A payroll tax.
Provider Payments	
Restores $40 billion to hospitals and other providers over five years as relief from payment reductions set in place by the Balanced Budget Act of 1997.	Restores $40 billion to hospitals and other providers over five years as relief from payment reductions set in place by the Balanced Budget Act of 1997.
Changes in Age of Eligibility	
Opposes any increase in the age of eligibility for Medicare. Allows certain individuals nearing retirement to buy in to Medicare.	Opposes any increase in the age of eligibility for Medicare.

PRESCRIPTION DRUG COVERAGE FOR SENIORS

Today: Medicare does not cover the costs of most outpatient prescription drugs, despite their increasingly important role in managing acute and chronic medical conditions. While nearly two-thirds of beneficiaries have some prescription drug coverage through employer retiree health plans, Medicaid, private supplemental insurance, or Medicare HMOs, some 14 million beneficiaries (35%) have no insurance coverage or assistance for medications and must pay for them out-of-pocket. Medicare beneficiaries without drug coverage fill fewer prescriptions and have higher out-of-pocket costs for their medications than those who have drug coverage. Even those beneficiaries with drug coverage may spend significant amounts out-of-pocket because of cost-sharing requirements and caps on their benefits. Moreover, prescription drug costs are escalating, jeopardizing access to needed medications for Medicare beneficiaries.

Both candidates have proposed plans to improve prescription drug coverage for people on Medicare. They differ, however, in their general approach (for example, the role of the public and private sectors), the details of the drug benefits covered under the program, and the overall level of federal spending to improve prescription drug coverage.

PRESCRIPTION DRUG COVERAGE FOR SENIORS

Comparison of Candidate Proposals — September 2000

GORE-LIEBERMAN	BUSH-CHENEY
General Approach	
Adds outpatient prescription drug benefit to Medicare. Available to all beneficiaries. (Effective 2002.)	For four years prior to implementation of comprehensive Medicare reform [see page 7], provides block grants giving states the option to help low-income Medicare beneficiaries with drug costs and to assist beneficiaries whose drug costs exceed $6,000. (Effective 2001.) Once comprehensive Medicare reform is implemented, drug coverage would be available to all beneficiaries through a choice of private or government-sponsored plans that offer Medicare benefits, prescription drugs, and other benefits.
Beneficiary Premiums	
Beneficiary pays a uniform national premium set to equal 50% of drug benefit costs.	Premiums would vary across plans. Beneficiary pays 75% of drug portion of premium; government pays 25%.
Benefits	
Pays 50% of drug costs up to annual cap of $2,000 in 2002 ($1,000 paid by beneficiary and $1,000 by Medicare). Amount rises to $5,000 in 2008 ($2,500 paid by beneficiary and $2,500 by Medicare). No deductible.	Benefits could vary across plans consistent with government standards.
Coverage of Catastrophic Drug Expenses	
Medicare would cover all out-of-pocket drug expenses above $4,000. This amount would rise annually for inflation in drug prices.	• In first four years, states would use block grant funding to pay all beneficiary drug expenditures exceeding $6,000. • Once comprehensive Medicare reform is implemented, plans would have to cover out-of-pocket drug spending and other out-of-pocket medical expenses above $6,000. No inflation adjustment specified.
Low-income Assistance	
For beneficiaries with incomes below about $11,000, Medicare pays premiums and coinsurance. For beneficiaries with incomes between about $11,000 and $12,500, Medicare pays premium subsidy on sliding scale. Medicaid determines eligibility for low-income assistance.	For beneficiaries with incomes below about $11,000, government pays premiums. For beneficiaries with incomes between about $11,000 to $14,600, government pays premium subsidy on a sliding scale. Subsidies administered through state programs for first four years. Medicaid determines eligibility for low-income assistance.
Spending	
$338 billion over 10 years for prescription drug benefit (Congressional Budget Office estimate).	$158 billion over 10 years (Bush campaign estimate). • $48 billion over four years for state block grants for assistance to low-income beneficiaries and coverage of out-of-pocket drug costs exceeding $6,000 for all beneficiaries • $110 billion over 10 years for prescription drugs *and* Medicare reforms.

LONG-TERM CARE

Today: "Long-term care" refers to the broad range of medical, social, personal care, and supportive services needed by people who have trouble caring for themselves due to a chronic illness or disability. The need for long-term care is greatest among the very old—those age 85 and older. However, people of all ages may need long-term care services. Most who do are not living in nursing homes; rather, they are being cared for in the community or in their own homes, or living with relatives or in non-institutional settings like assisted living facilities.

Long-term care services are very expensive, most long-term care services are not covered by Medicare, and few people have private long-term care insurance. As a result, most people requiring nursing home care eventually exhaust their savings and become eligible for Medicaid, the federal-state program that covers the costs of health and long-term care services for the poor.

Both candidates support changes in the tax laws to provide financial aid to families with long-term care needs. They differ in terms of the emphasis they place on helping people plan and save to meet their own long-term care needs and in creating new government programs to support families needing long-term care services.

LONG-TERM CARE

Comparison of Candidate Proposals — September 2000

GORE-LIEBERMAN	BUSH-CHENEY
General Approach	
Supports providing a tax credit to families to help pay for long-term care expenses. Establishes a new public program to provide support services.	Supports providing incentives through changes in tax policy to help families plan to meet their own long-term care needs and provide care for elderly family members at home.
Long-term Care Financing	
No stated position.	• Allows taxpayers to deduct 100% of the cost of private long-term care insurance premiums. The deduction would be available to all individuals who buy long-term care insurance regardless of whether they claim the standard deduction or itemize their tax returns. • Also supports the expansion of medical savings accounts, which would allow people to save money tax-free that can then be used to pay for long-term care as well as medical services.
Support for Caregivers	
Allows up to a $3,000 a year tax credit for families to help pay for long-term care services like home care, adult day care, and respite care.	Allows a tax exemption (currently valued at $2,750) for each elderly spouse, parent, or relative whom a caregiver tends to in his or her home.
Public Programs	
Establishes a National Caregiving Program to support families who care for elderly relatives with chronic illness or disability by creating "one-stop-shop" resource centers for respite care, and for information about services, counseling, and support.	No stated position.

Information for this side-by-side was derived primarily from the candidates' Web sites and other materials. The report was reviewed by each of the campaigns prior to publication.

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