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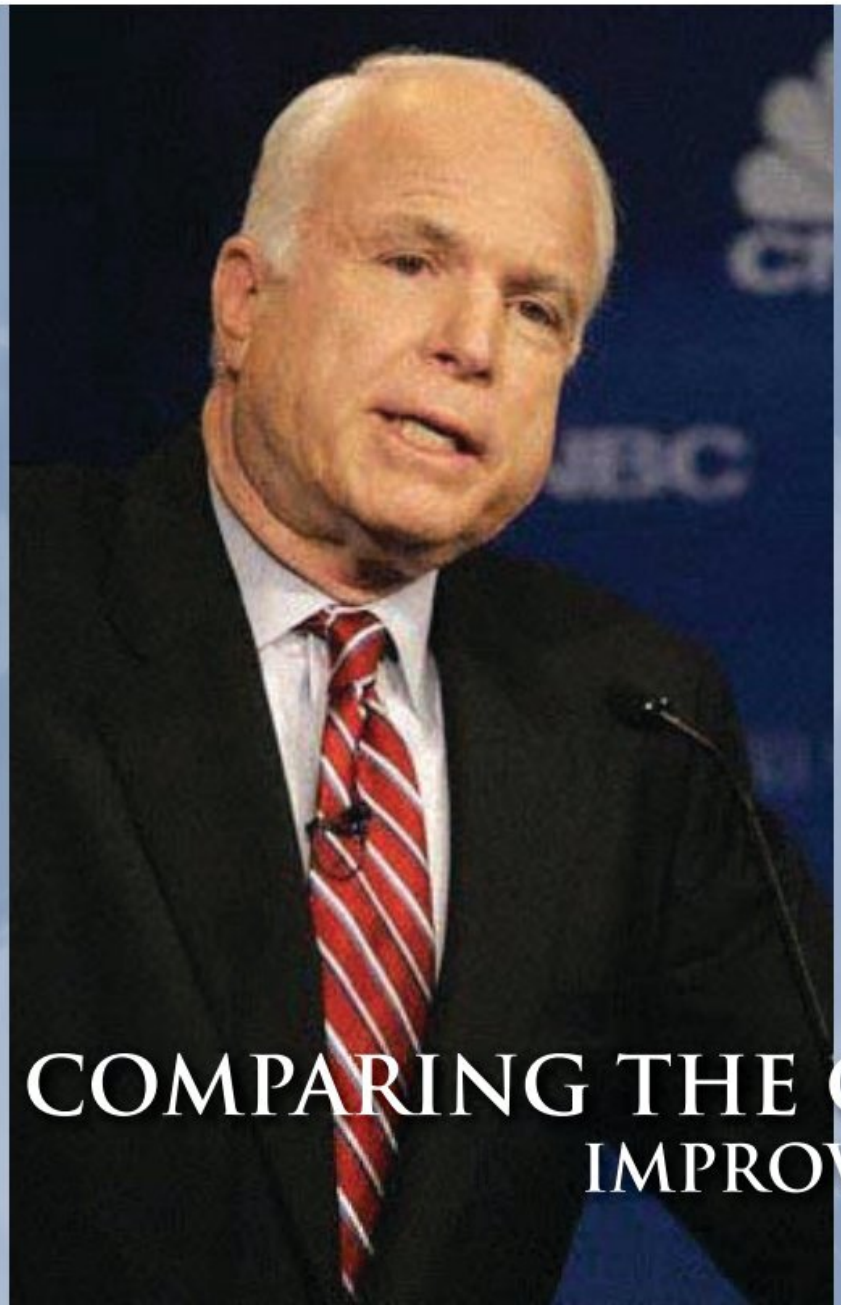

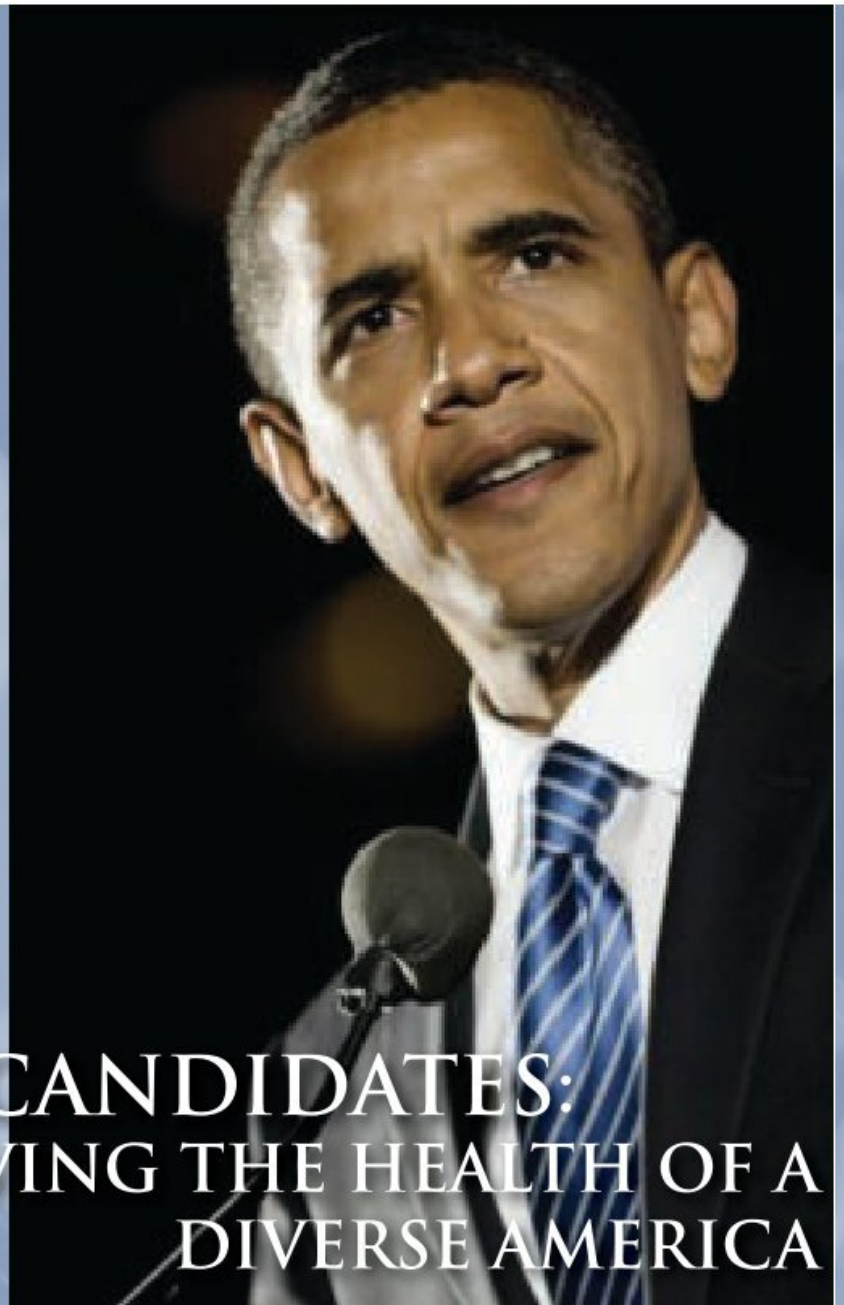

COMPARING THE CANDIDATES:
IMPROVING THE HEALTH OF A DIVERSE AMERICA

Democratic and Republican Presumptive Presidential Nominees on Health Care: Implications for Improving Access to Affordable, High Quality Care for America's Minorities[1]

Expanding Access to Affordable Health Insurance Coverage			
	Barack Obama[2]	**John McCain[3]**	**Implications for Racial/Ethnic Minorities**
Party Affiliation	• Democrat	• Republican	
Insurance Market Reforms	• Establish a new public plan for: individuals not covered through their employer or a current public program; self-employed; and small businesses. Options would be similar to those available to federal employees. • National Health Insurance Exchange (NIE) will be made available to help individuals enroll in the new public plan or purchase an approved private plan. • Income-based subsidies will be made available for individuals and families based on definition of need. • Medicare to remain intact for older and disabled Americans. • Guaranteed eligibility; no American will be turned away from any insurance plan because of illness or pre-existing conditions.	• Develop a Guaranteed Access Plan (GAP) to allow individuals denied insurance or with pre-existing conditions to obtain insurance through state-run high risk pool administered through private insurers that would establish "reasonable" premium limits. • Consider options such as creating a non-profit corporation that would contract with insurers to cover patients who have been denied insurance and could join with other state plans to enlarge pools and lower overhead costs. • Encourage competition to improve quality of health insurance with greater variety to match needs. • Expand Health Savings Accounts (HSAs). • Expand veterans' ability to use VA benefits to pay for timely, high quality health care.[4]	**Obama:** • New public plan could help expand coverage for minorities; effectiveness by race/ethnicity requires monitoring to ensure that disparities in affordability and access to quality health care are reduced. [5] Extensive outreach or enrollment assistance may be required for some populations (e.g., uninsured immigrant children). • NIE standards for private sector plans may help to ensure low income minorities have access to affordable and comprehensive care; sustainability likely to be challenging without cost-containment. **McCain:** • State high-risk pools have had limited success to date making coverage affordable to people with pre-existing conditions. • People with health problems may seek out states with community rating, and healthier individuals may seek coverage in less regulated states, thereby increasing premiums, and making coverage less affordable for seriously ill, low income minority populations.[6] • HSAs have not proven effective to date in expanding coverage to uninsured low income populations; benefits may be limited to healthy, higher-income minorities. • Minority veterans would have better access to needed health care.
Mandatory vs. Voluntary Insurance Coverage	• Mandatory coverage for children through public or private plans. • Expansion of coverage to young adults up to age 25 to maintain insurance through parents' plan. • Voluntary coverage for adults.	• Voluntary coverage for both children and adults.	**Obama:** • Mandate for children would build on the State Children's Health Insurance Program (SCHIP) to expand coverage to minority children currently uninsured; young minority adults with insured parents could gain coverage. • Voluntary emphasis for adults does not guarantee expansion of coverage for low-income minority adults. Ability to expand coverage voluntarily may be limited without significant subsidies. **McCain:** • Voluntary emphasis does not guarantee expansion of coverage for low income, minority children, or adults. Ability to expand coverage voluntarily may be limited without significant subsidies.
Employer Role	• Employers that do not offer "meaningful" coverage or make a "meaningful" contribution to employee coverage will be required to contribute a percentage of payroll toward the costs of the new public plan.	• Reduce or end most state insurance regulation especially affecting workplace coverage. • Reduce tax preference for employers. • Option of employer based coverage; reduce support for employer role in subsidizing insurance for employees.	**Obama:** • Catastrophic cost coverage assistance for minority employees and others may increase employee premiums. • Uncertainty about amount of penalty on employers that do not participate. A large penalty could unintentionally decrease wages for employees, to the detriment of low income minorities.[7] **McCain:** • Shift away from employer coverage may encourage shift of healthier workers to individual coverage, causing adverse selection and rising premiums in employer coverage for minority and other workers. May encourage some employers to drop coverage.

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Federal Tax Credits and Subsidies	• Make federal income-related subsidies available to help low-and middle-income individuals and families buy the new public plan or other qualified insurance.[4] • Federal subsidies would partially reimburse employers for their catastrophic health care costs if the employers guaranteed that premium savings would be used to reduce employee premiums.[4] • Federal subsidies for small employers offering health insurance.[7]	• Refundable tax credit of up to $2,500 (individuals) and $5,000 (families) to all individuals and families for the purchase of insurance.[4] • Federal income-related premium subsidies to individuals enrolled in the GAP. These are intended to target those who are in high-risk health insurance pools.[4]	**Obama:** • Uncertainty around impact the subsidies would have on coverage rates for low income minorities; details on the size and scale of subsidies are largely absent.[7] **McCain:** • Direct assistance to provide some offsets for insurance; uncertainty as to whether subsidies would be sufficient to motivate low-income families to take up the coverage, and whether coverage would be comprehensive and out of pocket costs affordable for family members with chronic conditions. • Low income minorities may find it difficult to make up the difference between the credit and premium (which is about $12,000 for family coverage through employer-based health plans.)[6] • Tax credit amount is fixed, regardless of income; may be insufficient for low income minorities with existing illnesses.[7] • Small and medium firms (often employing large percentages of minorities) may choose to drop coverage if they know their employees could obtain substantial tax credits for non-group coverage.[7]
State Flexibility	• Support states continuing to experiment with health care reform, but must meet minimum new public plan standards.	• Allow states flexibility to alternate forms of access, coordinate Medicaid payments, use private insurance for Medicaid, and create alternative insurance policies.	**Obama:** • Minimum health care insurance requirements would set a "floor" for an as yet undefined level of coverage. May help to reduce state disparities in coverage and access since states with highest minority population rates have the highest uninsured rates. **McCain:** • Low income minorities in states actively pursuing reforms and strategies to expand coverage could benefit. Has potential to perpetuate state disparities in coverage and access. State coverage expansion efforts may not be sufficient without significant federal financing.
Financing	• $50-65 billion per year when phased in financing comes from savings in health care system—eliminating excessive subsidies for Medicare Advantage and others. • Tax cut discontinuation for those earning over $250,000.[4]	• Not specified but indicates cost containment would be a focus.[4]	**Obama:** • Full funding from proposed sources may not materialize, which would limit amount of subsidies available to help low income minorities purchase coverage. **McCain:** • Uncertain implications for minorities due to lack of specificity.
Expanding Access to Health and Medical Care			
Sources of Care	• Work with schools to create more healthful environments, including grant support for health screenings and clinical services.	• Support expansion of care settings to non-traditional venues to improve convenience, accessibility, and affordability (e.g., walk in clinics and retail outlets provide opportunities for quick access to simple care). • Use telemedicine to connect community health clinics to resources where services are limited.[6]	**Obama:** • Cites importance of schools for prevention, screening, early intervention, and care for low income and minority children. **McCain:** • Walk-in clinics and retail outlets may provide expanded opportunities for low income minorities to access basic prevention services. • Telemedicine may expand care to underserved minority communities, but financing is not specified.

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Expanding Access to Health and Medical Care			
Prevention	• Tackle root causes of health **disparities** by promoting prevention. • Emphasize collaboration across multiple sectors for prevention, health promotion and early intervention. • Require coverage of preventive services, such as cancer screenings and smoking cessation, in federally-funded health plans. • Promote employee health by expanding and rewarding worksite prevention services.	• Increase focus on wellness programs and increase coverage for preventive services.[6] • Support making patients the center of care and giving them a larger role in prevention. • Work with employers and insurance companies to promote smoking cessation.	**Obama:** • Acknowledges a need for broad prevention strategies and collaboration across public agencies to address social determinants that contribute to racial/ethnic disparities. **McCain:** • No specificity about reducing disparities through prevention. **Both:** • Wellness, prevention programs in private sector could benefit minorities with employer-coverage.
Public Health	• Address root causes of health **disparities** by promoting public health. • Work with schools to provide healthy dietary choices and expand physical education. • Develop national and regional strategy for public health and align funding for support. • Encourage development of healthy environments for healthy food choices and physical fitness; restrict tobacco and alcohol advertising aimed at children.	• Support greater development of public health infrastructure. • Support the expansion of healthy dietary choices in schools for children.[6] • Support the use of public health initiatives to encourage individuals to prevent chronic disease, receive appropriate tests for early detection, and follow treatment guidelines.[6]	**Obama:** • Explicitly states intention to reduce disparities through public health initiatives; school-based initiatives could benefit minority children. • Regional, national coordination could help target resources to low income, underserved communities. Better access to fresh produce and recreation would promote healthy choices in minority communities. **McCain:** • Stronger public health infrastructure and initiatives to promote early detection and treatment could benefit low income, underserved minorities; school-based initiatives could benefit minority children.
Protection/ Expansion of Health Care Safety Net	• Support adequate funding of safety net and technical resources to improve capacity of safety net providers to care for underserved populations.	• Expand availability of walk-in and community clinics; not specific to safety net providers.	**Obama:** • Because low-income minorities disproportionately rely on safety-net institutions, safety net expansion implies greater access to care for minorities in underserved/low income communities. **McCain:** • No specific mention of "safety net"; expansion of outpatient clinics in underserved communities could benefit low income minorities.
Health Workforce Diversity and Cultural Competence	• Invest in public health workforce recruitment efforts such as loan repayment or forgiveness programs to make health care workforce more diverse. • Expand outreach and educational efforts to improve the cultural competence and language skills of hospital providers.	• Not specified.	**Obama:** • Increasing incentives for minorities to enter health care professions and work in minority/underserved communities, as well as explicitly supporting cultural competence and language assistance efforts; offers potential to improve access to quality health care for minorities. **McCain:** • No specificity on cultural competence and workforce diversity.
Health Care Quality Improvement			
Incentives/ Penalties	• Reward providers for reaching performance thresholds on valid outcome measures, and hold hospitals and plans accountable for **disparities** in quality. • Fund/implement evidence-based interventions; promote new models for addressing physician errors, strengthen doctor/patient relationship and reduce malpractice suits.	• Reform Medicare and Medicaid to allow for compensation for diagnosis, prevention, and care coordination. • No payment for preventable errors or mismanagement.	**Obama:** • Explicitly states the intent to use funding and quality requirements to increase responsibility for addressing disparities in outcomes; support for innovations in doctor-patient relationship offers opportunity to incorporate culture/community dynamics into improving minority care. **McCain:** • Encourages but does not specify adjustments (and financial disincentives) for key health care priorities affecting minorities.

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Health Care Quality Improvement			
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Data Collection, Public Reporting, and Pay-for-Performance	• Require hospitals/providers to collect and publicly report measures of health care cost and quality, including data on preventable medical errors, nurse staffing ratios, hospital-acquired infections, and **disparities** in care; align reimbursement with quality care. • NIE would evaluate performance of participating health plans on costs, quality, and other measures.	• Collect information on practice patterns, costs, and effectiveness of providers. • Develop national standards for measuring and recording treatments and outcomes.[6] • Make more information publicly available on treatment options. • Require transparency for medical outcomes, care quality, costs, and prices and pay only for care that is the "right care".[6]	**Obama:** • Requiring providers to monitor/report progress on reducing disparities could lay foundation for national benchmarks and public reporting. **McCain:** • No specificity about collection, reporting of data related to racial/ethnic health disparities. **Both:** • Pay-for-performance initiatives need to consider the potential for creating disincentives for providers to care for minorities, as minorities often face greater barriers to treatment compliance and have higher illness rates.[5]
Promoting Research and Evidence-Based Medicine	• Support development and dissemination of best practices. • Establish an institute to guide reviews and research on comparative effectiveness for providers to make best decisions. • Support cancer research and programs to reduce obesity.	• Support documenting and disseminating information on best practices to eliminate excess costs. • Increase federally funded research on chronic illness and treatment of patients with multiple chronic conditions.[6]	**Both:** • Focus on chronic disease holds promise for the disproportionately higher number of minorities suffering from these illnesses, especially if language and cultural needs and circumstances contributing to their disease are central to these efforts. • Strong support for best-practices dissemination could reduce disparities if applications of evidence-based regimens are implemented broadly to benefit minority populations and communities.
Information Technology	• Invest $50 billion over 5 years to adopt electronic medical records and other health information technology.[4]	• Promote the rapid deployment of information systems and technology that allows doctors to practice across state lines.	**Both:** • Potential to decrease unnecessary spending from duplication of care, preventable errors, inefficient paper billing, and other administrative inefficiencies that will benefit minorities and others.
Care Coordination and Disease Management	• Improve prevention and management of chronic conditions.[4] • Plans participating in new public plan, Medicare or FEHBP must use "proven" disease management programs.[6] • Support care management programs; encourage medical home-type models to improve coordination and integration, especially for chronic conditions.	• Encourage cost reduction through disease management and individual case management as well as health and wellness programs. • Coordinate care by ensuring that patients pay a single bill for high quality disease care, making providers accountable and encouraging collaboration. • Providing "medical homes" by ensuring patients do not have to change doctors with their jobs and are able to deal with doctors who know about their medical history.	**Both:** • Strong support for disease management may assist minority patients in treatment adherence and self-management if language, health literacy, and cultural competence are integrated into related protocols. • Emphasis on supporting medical homes may significantly and positively impact minorities who are much less likely to have a regular source of care. • Using disease and case management to reduce costs without also targeting better health outcomes could have negative impact on minorities with chronic conditions or complex illnesses.

Notes and References:

1. Prepared for the **Joint Center for Political and Economic Studies** by: Dennis Andrulis, PhD, MPH, David B. Smith, PhD, and Nadia J. Siddiqui, MPH at the ***Center for Health Equality at Drexel University School of Public Health***; and Lisa Duchon, PhD at ***Health Management Associates***. Find a complete version of this table in the forthcoming report entitled "Comparing the Democratic and Republican Presidential Candidates on their Health Care Platforms: Implications for Improving Access, Affordability and Quality for America's Minorities."
2. Unless noted otherwise, Senator Barack Obama's positions are directly drawn from the following campaign documents found on his website (www.barackobama.com): Barack Obama's Plan for a Healthy America; Barack Obama: Working for the Asian American and Pacific Islander Community; and Latino Blueprint for Change: Barack Obama's Plan for America.
3. Unless noted otherwise, Senator John McCain's positions are directly drawn from his campaign document, Straight Talk on Health System Reform, at http://www.johnmccain.com/Informing/Issues/19ba2f1c-c03f-4ac2-8cd5-5cf2edb527cf.htm and his remarks made at: Day Two of the "Call to Action Tour" April 29, 2008.
4. Kaiser Family Foundation, 2008 Presidential Candidate Health Care Proposals: Side-by-Side Summary, www.health08.org.
5. National REACH Coalition. Creating More Equity in Health: A Comprehensive Approach to Health Reform. June 2008.
6. Collins SR and Kriss JL. Envisioning the Future: The 2008 Presidential Candidates' Health Reform Proposals. The Commonwealth Fund Report, January 2008.
7. Burman L et al. An Updated Analysis of the 2008 Presidential Candidates' Tax Plans. Tax Policy Center, Urban Institute and Brookings Institution, July 23, 2008.

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