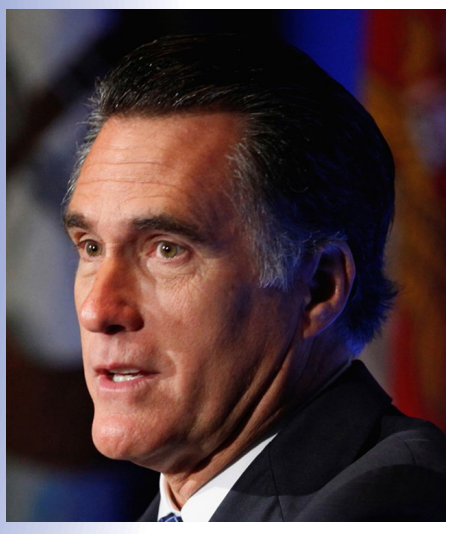
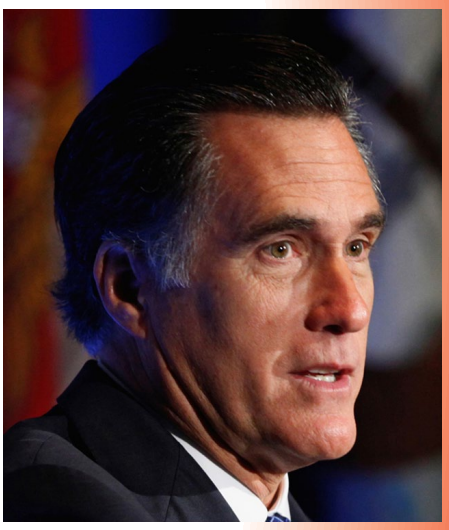




ObamaCare

versus

RomneyCare

versus

RomneyCandidateCare

A National and State-by-State Analysis

Families USA

The development of this Families USA report was aided enormously by three distinguished health policy analysts who played significant roles in the creation and promotion of RomneyCare and ObamaCare. They are as follows:

Stuart Altman is the Sol C. Chaikin Professor of National Health Policy at the Heller School for Social Policy and Management at Brandeis University. Dr. Altman served as a Deputy Assistant Secretary of Health, Education, and Welfare in the Nixon Administration and was one of the architects of Nixon's health reform plan. He was Chair of the Prospective Payment Assessment Commission for 12 years under Presidents Ronald Reagan, George H. W. Bush, and Bill Clinton. President Clinton also appointed him to the Bipartisan Commission on the Future of Medicare.

Jonathan Gruber is a Professor of Economics at the Massachusetts Institute of Technology. Dr. Gruber served as a Deputy Assistant Secretary for Economic Policy in the Treasury Department. He is a gubernatorial appointee to the Board of the Massachusetts Commonwealth Health Insurance Connector Authority. He is also the Director of the National Bureau of Economic Research's Program on Children. The new data in this report were derived from a model developed by Dr. Gruber.

John McDonough is a Professor of Practice at the Harvard School of Public Health, and he is the Director of the Harvard School of Public Health's Center for Public Health Leadership. From 2003 to 2008, Dr. McDonough served as the Executive Director of Health Care for All in Massachusetts, where he played a central role in the passage of RomneyCare in 2006. He served as a Senior Adviser to the Senate Health, Education, Labor, and Pensions Committee, where he played a major role in developing the health insurance expansion provisions of ObamaCare.

Families USA is a nonprofit, nonpartisan, 501(c)(4) organization that does not endorse, support, or oppose political candidates. Its mission is to achieve high-quality, affordable health coverage and care for all Americans.

Cover design: Nancy Magill, Families USA

Photos: President Barack Obama (Associated Press/Rex Features); Governor Mitt Romney (Associated Press/Manuel Balce Ceneta)

Introduction

America is at a crossroads in terms of the direction it will take on health care.

To help illuminate the possible paths forward, Families USA has explored the positions and records of the presidential candidates. To do this, we looked at the health reform law enacted in Massachusetts under the leadership of Governor Mitt Romney (which we refer to as RomneyCare throughout this report), at the health care law passed by Congress and enacted under the leadership of President Barack Obama (which we refer to as ObamaCare), and at the public positions on health care taken by Governor Romney in his role as the Republican presidential nominee (which we refer to as RomneyCandidateCare). While RomneyCare and ObamaCare have substantial similarities, it is clear that RomneyCandidateCare represents a significant shift in direction, presenting an obvious contrast with both RomneyCare and ObamaCare.

Governor Mitt Romney signed the Massachusetts Health Insurance Law on April 12, 2006.[1] In doing so, he proudly stated that the new law would expand health coverage and protections for people throughout the state. Less than a year later, the governor touted RomneyCare as a potential model for replication. In remarks to reporters after a speech to the Republican Study Committee in Baltimore on February 2, 2007, he said, "I'm proud of what we've done," and added that the law, if successfully implemented, "will be a model for the nation."[2]

When RomneyCare was enacted in 2006, Massachusetts already had one of the lowest uninsured rates among the 50 states (10.4 percent[3]). However, as Governor Romney anticipated, RomneyCare significantly improved health coverage. According to the latest Census Bureau report, only 3.4 percent of Massachusetts residents are uninsured—an enviable record that is far better than that of any other state in the nation.[4] As a result, policy makers in the nation's capitol turned to RomneyCare as a model to inform and guide the design of national health reform.

On March 23, 2010, President Barack Obama signed into law ObamaCare, the *Patient Protection and Affordable Care Act*. ObamaCare is similar in many respects to RomneyCare. Both laws expand affordable health insurance options for middle- and low-income individuals and families through the creation of new health insurance marketplaces with consumer protections, as well as through public coverage. Indeed, an examination of key provisions of ObamaCare and RomneyCare demonstrates the clear parallels.

Today, as a candidate for President, Governor Romney has been emphatically critical of ObamaCare and has repeatedly stated his intention to repeal the law. Moving away from the Massachusetts reform model he signed into law, Governor Romney has signaled his support for a dramatically different set of proposals.

In fact, RomneyCandidateCare includes health policies that would make it difficult, if not impossible, for other states to move forward with reforms similar to either RomneyCare or ObamaCare. First, Governor Romney would repeal ObamaCare, including measures in the law that provide new protections for consumers with private insurance (such as banning annual and lifetime caps on coverage) and that expand affordable coverage options. Paradoxically, RomneyCare was built on a very similar foundation of protections and new coverage options.

Second, Governor Romney would repeal ObamaCare's substantial premium tax credits that would help middle-class families purchase insurance in the new health insurance marketplaces. Instead, RomneyCandidateCare would enact a federal income tax deduction for the cost of purchasing coverage in today's existing insurance markets. As documented on page 4, the proposed tax deduction would provide significantly less help to families than the tax credit offered under ObamaCare.

Third, Governor Romney has proposed converting the Medicaid program to a block grant while significantly reducing federal Medicaid funding provided to the states. Ironically, federal Medicaid dollars were key to the success of health reform in Massachusetts. By cutting these dollars, Governor Romney jeopardizes both RomneyCare's future and the potential for enacting similar reforms in every other state in the country.

This report examines the similarities between ObamaCare and RomneyCare, and it presents the clear contrasts between ObamaCare and the governor's currently articulated health positions in RomneyCandidateCare.

Similarities between ObamaCare and RomneyCare

To illustrate the similarities between ObamaCare and RomneyCare, Table 1 presents new national data showing the effects each approach would have if it were fully implemented nationwide in 2016. (That is, we contrast the projected effects of ObamaCare with the projected effects of nationwide implementation of a plan that is identical to RomneyCare.) These new national data include the number of middle-class and working families who would be eligible for premium tax credits, the value of those credits, the out-of-pocket health care costs families would face, and the number of uninsured people who would gain health coverage.

Table 1.
Similarities between ObamaCare and RomneyCare

Comparison Criteria	ObamaCare	RomneyCare
Number of People Receiving Premium Tax Credits, 2016	20,340,000	19,490,000
Average Value of Premium Tax Credits, 2016	$4,231	$6,292
Average Spending on Health Care by People with Non-Group Coverage, 2016	$5,985	$5,782
Change in the Number of Uninsured, 2016	-30,700,000	-29,640,000
Change in the Number of Uninsured, 2022	-32,930,000	-33,990,000

Source: Estimates prepared for Families USA by Jonathan Gruber, MIT. Data are for the non-institutionalized, non-elderly, non-Medicare-eligible population.

We selected 2016 for our new estimates because it is the last year of the next president's term in office and because it is also when ObamaCare will be fully operational. Although some provisions of ObamaCare have already been implemented, the major provisions of the law that expand coverage begin to take effect in January 2014. For example, the key provisions that will help millions of Americans with the cost of health insurance premiums are not yet in effect. In the comparison of the number of uninsured, we look at both 2016 and 2022 in order to demonstrate how the gap between the two approaches grows over time.

Key Findings: ObamaCare versus RomneyCandidateCare

Our report provides tables with new national and state-level data that illustrate the starkly different effects of the two candidates' current approaches to addressing health reform. Again, our analysis assumes that both ObamaCare and, in this case, RomneyCandidateCare, are fully implemented nationwide in 2016. Our candidate comparison includes data on the number of middle-class and working families who would be eligible for premium tax credits and the value of those credits, the out-of-pocket health care costs families would face, and the number of uninsured people who would gain or lose health coverage (looking at both 2016 and 2022 for the uninsured). Although the report's tables provide data for all states, in our Key Findings, we highlight the results in states that are currently receiving disproportionate attention in the media.[5]

ObamaCare and Medicare

As part of our analysis of ObamaCare compared to RomneyCandidateCare, we also look at the impact of ObamaCare on Americans who rely on Medicare. The Discussion section takes a closer look at claims that Medicare benefits are cut to pay for ObamaCare, and it corrects misconceptions regarding the effects of the Medicare savings that are achieved under the law. In point of fact, ObamaCare actually extends the life of the Medicare trust fund, and it expands traditional Medicare benefits, as shown in our Key Findings. Specifically, we include state-level data on the number of Medicare beneficiaries who are receiving new, free preventive health services under ObamaCare and who are receiving new help in the Part D drug coverage gap known as the doughnut hole. Since some of ObamaCare's key Medicare changes are already completely or partially operational, we base our Key Findings on the most recent annual data available from the Centers for Medicare and Medicaid Services (CMS). RomneyCandidateCare would repeal these new Medicare benefits.

As our data show, RomneyCandidateCare, compared to ObamaCare, would substantially increase the number of uninsured people across the nation; would leave millions of middle-class, working families with considerably higher out-of-pocket health care costs; and would take away significant preventive and prescription drug services for seniors and people with disabilities who rely on Medicare.

Key Findings

Help with the Cost of Health Insurance Premiums in 2016

- **Nationally**
  - Although both ObamaCare and RomneyCandidateCare provide help with health insurance premiums through the federal tax system, the former does it through *tax credits* and the latter through *tax deductions*. As a result, not only does ObamaCare provide help to more than twice as many people, but the average amount of help provided to each person is also much larger (Table 2).
  - Under ObamaCare, 20.3 million Americans purchasing individual health coverage would receive help with the cost of health insurance premiums in 2016 through tax credits (Table 2).
  - Under RomneyCandidateCare, fewer than half as many Americans (fewer than 10.1 million people) would receive help with premiums through tax deductions (Table 2).
  - Under ObamaCare, the average amount of help with premiums would be $4,231 in 2016 (Table 2).
  - Under RomneyCandidateCare, the average amount of help with premiums would be $2,490 in 2016 (Table 2).
  - As a result, the size of the average premium tax credit would be 70 percent higher under ObamaCare than it would be under RomneyCandidateCare.
- **By State** (Table 2)
  - In **Colorado**
    - Under ObamaCare, 340,000 people would receive an average of $4,572 in premium help in 2016.
    - Under RomneyCandidateCare, 250,000 people would receive an average of $1,995 in premium help in 2016.
  - In **Florida**
    - Under ObamaCare, 1,620,000 people would receive an average of $4,216 in premium help in 2016.
    - Under RomneyCandidateCare, 800,000 people would receive an average of $3,174 in premium help in 2016.

- In **Iowa**
  - Under ObamaCare, 170,000 people would receive an average of $5,256 in premium help in 2016.
  - Under RomneyCandidateCare, 100,000 people would receive an average of $2,637 in premium help in 2016.
- In **Michigan**
  - Under ObamaCare, 650,000 people would receive an average of $4,674 in premium help in 2016.
  - Under RomneyCandidateCare, 240,000 people would receive an average of $3,604 in premium help in 2016.
- In **Nevada**
  - Under ObamaCare, 190,000 people would receive an average of $3,731 in premium help in 2016.
  - Under RomneyCandidateCare, 110,000 people would receive an average of $2,758 in premium help in 2016.
- In **New Hampshire**
  - Under ObamaCare, 80,000 people would receive an average of $4,256 in premium help in 2016.
  - Under RomneyCandidateCare, 50,000 people would receive an average of $2,031 in premium help in 2016.
- In **North Carolina**
  - Under ObamaCare, 750,000 people would receive an average of $4,170 in premium help in 2016.
  - Under RomneyCandidateCare, 290,000 people would receive an average of $2,138 in premium help in 2016.
- In **Ohio**
  - Under ObamaCare, 750,000 people would receive an average of $4,646 in premium help in 2016.
  - Under RomneyCandidateCare, 350,000 people would receive an average of $1,977 in premium help in 2016.
- In **Pennsylvania**
  - Under ObamaCare, 570,000 people would receive an average of $4,466 in premium help in 2016.
  - Under RomneyCandidateCare, 320,000 people would receive an average of $3,035 in premium help in 2016.

Table 2.

Help with the Cost of Health Insurance Premiums, by State, 2016

State	ObamaCare		RomneyCandidateCare	
	Number Receiving Help	Average Value Per Recipient	Number Receiving Help	Average Value Per Recipient
Alabama	280,000	$5,245	140,000	$2,488
Alaska	60,000	$3,525	20,000	$2,036
Arizona	620,000	$4,035	300,000	$1,931
Arkansas	210,000	$4,031	100,000	$3,301
California	2,730,000	$3,792	1,450,000	$2,381
Colorado	340,000	$4,572	250,000	$1,995
Connecticut	150,000	$5,212	100,000	$2,216
Delaware	60,000	$3,429	20,000	$1,830
District of Columbia	30,000	$4,137	20,000	$1,499
Florida	1,620,000	$4,216	800,000	$3,174
Georgia	940,000	$3,885	370,000	$2,218
Hawaii	40,000	$6,122	30,000	$1,645
Idaho	160,000	$3,815	70,000	$2,311
Illinois	600,000	$4,071	420,000	$2,780
Indiana	510,000	$4,055	160,000	$2,440
Iowa	170,000	$5,256	100,000	$2,637
Kansas	170,000	$4,590	90,000	$2,621
Kentucky	190,000	$3,920	90,000	$2,352
Louisiana	260,000	$5,540	150,000	$2,337
Maine	80,000	$4,237	30,000	$2,343
Maryland	230,000	$4,441	270,000	$2,615
Massachusetts	100,000	$3,903	160,000	$1,633
Michigan	650,000	$4,674	240,000	$3,604
Minnesota	250,000	$4,783	200,000	$2,969
Mississippi	240,000	$4,575	70,000	$3,204
Missouri	400,000	$4,324	220,000	$1,876
Montana	100,000	$4,690	50,000	$1,537
Nebraska	120,000	$5,445	70,000	$2,751
Nevada	190,000	$3,731	110,000	$2,758
New Hampshire	80,000	$4,256	50,000	$2,031
New Jersey	510,000	$4,697	290,000	$2,538
New Mexico	160,000	$4,398	50,000	$1,286
New York	1,100,000	$4,530	540,000	$2,870
North Carolina	750,000	$4,170	290,000	$2,138
North Dakota	60,000	$4,361	30,000	$3,001
Ohio	750,000	$4,646	350,000	$1,977
Oklahoma	310,000	$3,985	130,000	$3,201
Oregon	190,000	$4,677	120,000	$2,288
Pennsylvania	570,000	$4,466	320,000	$3,035
Rhode Island	60,000	$4,276	40,000	$2,303
South Carolina	380,000	$3,904	130,000	$2,714
South Dakota	70,000	$3,223	30,000	$1,954
Tennessee	430,000	$4,781	190,000	$3,467
Texas	1,890,000	$3,922	700,000	$1,956
Utah	160,000	$2,990	90,000	$3,354
Vermont	40,000	$4,358	20,000	$2,042
Virginia	470,000	$3,700	240,000	$1,919
Washington	430,000	$4,656	240,000	$2,304
West Virginia	90,000	$4,176	20,000	$1,161
Wisconsin	300,000	$4,333	130,000	$1,858
Wyoming	50,000	$3,902	20,000	$4,298
U.S. Total/Average	**20,340,000**	**$4,231**	**10,090,000**	**$2,490**

Source: Estimates prepared for Families USA by Jonathan Gruber, MIT. Data are for the non-institutionalized, non-elderly, non-Medicare-eligible population.

- In **Virginia**
  - Under ObamaCare, 470,000 people would receive an average of $3,700 in premium help in 2016.
  - Under RomneyCandidateCare, 240,000 people would receive an average of $1,919 in premium help in 2016.
- In **Wisconsin**
  - Under ObamaCare, 300,000 people would receive an average of $4,333 in premium help in 2016.
  - Under RomneyCandidateCare, 130,000 people would receive an average of $1,858 in premium help in 2016.

Health Care Spending by Families with Private Health Insurance in 2016

- **Nationally**
  - As a result of the difference in the amount of help available with premiums and in the quality of insurance plans, middle-class families who purchase health insurance on their own (non-group coverage) would spend considerably more out of pocket in 2016 under RomneyCandidateCare than they would under ObamaCare.
    - Under ObamaCare, the average spending on health care (including premiums and out-of-pocket costs) would be $5,985 (Table 3).
    - Under RomneyCandidateCare, the average spending on health care (including premiums and out-of-pocket costs) would be $11,481 (Table 3).
    - Accordingly, under RomneyCandidateCare, average health care spending by a household would be 92 percent higher than under ObamaCare (Table 3).
- **By State** (Table 3)
  - In **Colorado**
    - Under ObamaCare, the average spending on health care would be $5,998 in 2016.
    - Under RomneyCandidateCare, the average spending on health care would be $9,069 in 2016.
  - In **Florida**
    - Under ObamaCare, the average spending on health care would be $5,651 in 2016.
    - Under RomneyCandidateCare, the average spending on health care would be $10,543 in 2016.

- In **Iowa**
  - Under ObamaCare, the average spending on health care would be $7,021 in 2016.
  - Under RomneyCandidateCare, the average spending on health care would be $11,163 in 2016.
- In **Michigan**
  - Under ObamaCare, the average spending on health care would be $5,043 in 2016.
  - Under RomneyCandidateCare, the average spending on health care would be $14,200 in 2016.
- In **Nevada**
  - Under ObamaCare, the average spending on health care would be $7,778 in 2016.
  - Under RomneyCandidateCare, the average spending on health care would be $12,306 in 2016.
- In **New Hampshire**
  - Under ObamaCare, the average spending on health care would be $6,206 in 2016.
  - Under RomneyCandidateCare, the average spending on health care would be $8,516 in 2016.
- In **North Carolina**
  - Under ObamaCare, the average spending on health care would be $4,908 in 2016.
  - Under RomneyCandidateCare, the average spending on health care would be $14,658 in 2016.
- In **Ohio**
  - Under ObamaCare, the average spending on health care would be $5,098 in 2016.
  - Under RomneyCandidateCare, the average spending on health care would be $10,096 in 2016.
- In **Pennsylvania**
  - Under ObamaCare, the average spending on health care would be $7,941 in 2016.
  - Under RomneyCandidateCare, the average spending on health care would be $13,820 in 2016.
- In **Virginia**
  - Under ObamaCare, the average spending on health care would be $5,583 in 2016.
  - Under RomneyCandidateCare, the average spending on health care would be $10,130 in 2016.
- In **Wisconsin**
  - Under ObamaCare, the average spending on health care would be $6,006 in 2016.
  - Under RomneyCandidateCare, the average spending on health care would be $10,044 in 2016.

Table 3.

Average Spending on Health Care (including premiums and out-of-pocket costs) by Families Who Purchase Non-Group Coverage, 2016

State	ObamaCare	RomneyCandidateCare
Alabama	$6,687	$10,332
Alaska	$5,804	$15,178
Arizona	$5,409	$11,024
Arkansas	$5,870	$11,437
California	$6,174	$11,584
Colorado	$5,998	$9,069
Connecticut	$8,710	$13,417
Delaware	$6,625	$9,644
District of Columbia	$4,543	$8,876
Florida	$5,651	$10,543
Georgia	$5,171	$10,922
Hawaii	$5,562	$8,507
Idaho	$6,107	$11,489
Illinois	$6,781	$12,921
Indiana	$5,246	$10,463
Iowa	$7,021	$11,163
Kansas	$6,688	$12,676
Kentucky	$6,274	$12,721
Louisiana	$6,910	$9,279
Maine	$6,278	$10,055
Maryland	$7,806	$9,399
Massachusetts	$8,601	$9,475
Michigan	$5,043	$14,200
Minnesota	$7,622	$14,207
Mississippi	$4,757	$10,291
Missouri	$6,158	$11,579
Montana	$5,091	$18,004
Nebraska	$5,913	$13,714
Nevada	$7,778	$12,306
New Hampshire	$6,206	$8,516
New Jersey	$6,175	$9,530
New Mexico	$5,171	$8,751
New York	$5,597	$12,645
North Carolina	$4,908	$14,658
North Dakota	$7,351	$17,300
Ohio	$5,098	$10,096
Oklahoma	$4,806	$11,111
Oregon	$6,135	$12,014
Pennsylvania	$7,941	$13,820
Rhode Island	$5,209	$10,699
South Carolina	$4,731	$12,505
South Dakota	$6,924	$12,515
Tennessee	$5,542	$14,536
Texas	$5,470	$8,913
Utah	$6,566	$13,781
Vermont	$5,922	$11,006
Virginia	$5,583	$10,130
Washington	$7,535	$12,397
West Virginia	$3,827	$6,952
Wisconsin	$6,006	$10,044
Wyoming	$6,070	$12,836
U.S. Average	**$5,985**	**$11,481**

Source: Estimates prepared for Families USA by Jonathan Gruber, MIT. Data are for the non-institutionalized, non-elderly, non-Medicare-eligible population.

Uninsured Americans in 2016

- **Nationally**
  - In the absence of ObamaCare or RomneyCandidateCare, the number of uninsured Americans under the age of 65 is projected to rise to 56.0 million by 2016 (Table 4).
  - Under ObamaCare, the number of uninsured Americans would *decrease* significantly, falling by 30.7 million by 2016 (Table 4).
  - In sharp contrast, under RomneyCandidateCare, the number of uninsured Americans would actually *increase*, rising by 11.2 million to 67.2 million by 2016 (Table 5).
  - Under RomneyCandidateCare, there would be 41.9 million more uninsured people in 2016 than under ObamaCare (Table 5).
- **By State** (Table 4)
  - In **Colorado**
    - Under ObamaCare, 390,000 people would gain health coverage by 2016.
    - Under RomneyCandidateCare, 190,000 people would lose health coverage by 2016.
  - In **Florida**
    - Under ObamaCare, 2,480,000 people would gain health coverage by 2016.
    - Under RomneyCandidateCare, 490,000 people would lose health coverage by 2016.
  - In **Iowa**
    - Under ObamaCare, 210,000 people would gain health coverage by 2016.
    - Under RomneyCandidateCare, 120,000 people would lose health coverage by 2016).
  - In **Michigan**
    - Under ObamaCare, 890,000 people would gain health coverage by 2016.
    - Under RomneyCandidateCare, 370,000 people would lose health coverage by 2016.
  - In **Nevada**
    - Under ObamaCare, 310,000 people would gain health coverage by 2016.
    - Under RomneyCandidateCare, 60,000 people would lose health coverage by 2016.

Table 4.

Uninsured People under the Age of 65, by State, 2016

State	Baseline Number Of Uninsured*	Change in Number of Uninsured	
		ObamaCare	RomneyCandidateCare
Alabama	780,000	-490,000	+160,000
Alaska	140,000	-90,000	+20,000
Arizona	1,440,000	-790,000	+260,000
Arkansas	600,000	-410,000	+110,000
California	7,990,000	-4,040,000	+2,350,000
Colorado	750,000	-390,000	+190,000
Connecticut	430,000	-190,000	+160,000
Delaware	110,000	-60,000	+50,000
District of Columbia	80,000	-20,000	+40,000
Florida	4,280,000	-2,480,000	+490,000
Georgia	2,140,000	-1,270,000	+210,000
Hawaii	110,000	-50,000	+50,000
Idaho	330,000	-230,000	+40,000
Illinois	2,130,000	-1,170,000	+420,000
Indiana	950,000	-610,000	+240,000
Iowa	410,000	-210,000	+120,000
Kansas	400,000	-220,000	+90,000
Kentucky	720,000	-400,000	+110,000
Louisiana	1,020,000	-640,000	+160,000
Maine	140,000	-90,000	+40,000
Maryland	830,000	-380,000	+190,000
Massachusetts	440,000	-100,000	+200,000
Michigan	1,430,000	-890,000	+370,000
Minnesota	580,000	-270,000	+200,000
Mississippi	690,000	-430,000	+70,000
Missouri	950,000	-610,000	+130,000
Montana	190,000	-120,000	+40,000
Nebraska	270,000	-150,000	+50,000
Nevada	630,000	-310,000	+60,000
New Hampshire	150,000	-80,000	+40,000
New Jersey	1,470,000	-850,000	+290,000
New Mexico	490,000	-260,000	+40,000
New York	3,430,000	-1,420,000	+910,000
North Carolina	1,790,000	-940,000	+240,000
North Dakota	90,000	-60,000	+20,000
Ohio	1,730,000	-1,030,000	+490,000
Oklahoma	700,000	-440,000	+80,000
Oregon	690,000	-420,000	+140,000
Pennsylvania	1,530,000	-830,000	+450,000
Rhode Island	130,000	-70,000	+40,000
South Carolina	1,050,000	-650,000	+140,000
South Dakota	120,000	-80,000	+20,000
Tennessee	1,030,000	-550,000	+180,000
Texas	6,900,000	-3,660,000	+670,000
Utah	440,000	-230,000	+50,000
Vermont	70,000	-40,000	+30,000
Virginia	1,220,000	-740,000	+150,000
Washington	1,060,000	-640,000	+210,000
West Virginia	280,000	-180,000	+60,000
Wisconsin	580,000	-340,000	+250,000
Wyoming	100,000	-60,000	+30,000
U.S. Total	**56,010,000**	**-30,700,000**	**+11,160,000**

Source: Estimates prepared for Families USA by Jonathan Gruber, MIT. Data are for the non-institutionalized, non-elderly, non-Medicare-eligible population.

*The baseline number of uninsured is the number of people who would be uninsured in 2016 in the absence of any of the reforms that are described in this analysis.

- In **New Hampshire**
  - Under ObamaCare, 80,000 people would gain health coverage by 2016.
  - Under RomneyCandidateCare, 40,000 people would lose health coverage by 2016.
- In **North Carolina**
  - Under ObamaCare, 940,000 people would gain health coverage by 2016.
  - Under RomneyCandidateCare, 240,000 people would lose health coverage by 2016.
- In **Ohio**
  - Under ObamaCare, 1,030,000 people would gain health coverage by 2016.
  - Under RomneyCandidateCare, 490,000 people would lose health coverage by 2016.
- In **Pennsylvania**
  - Under ObamaCare, 830,000 people would gain health coverage by 2016.
  - Under RomneyCandidateCare, 450,000 people would lose health coverage by 2016.
- In **Virginia**
  - Under ObamaCare, 740,000 people would gain health coverage by 2016.
  - Under RomneyCandidateCare, 150,000 people would lose health coverage by 2016.
- In **Wisconsin**
  - Under ObamaCare, 340,000 people would gain health coverage by 2016.
  - Under RomneyCandidateCare, 250,000 people would lose health coverage by 2016.

Table 5.

Difference in Non-Elderly Uninsured under ObamaCare and RomneyCandidateCare, 2016

	ObamaCare	RomneyCandidateCare
Baseline Uninsured	56,010,000	56,010,000
Change	-30,700,000	+11,160,000
Total Uninsured	25,310,000	67,170,000

Difference 41,860,000

Source: Estimates prepared for Families USA by Jonathan Gruber, MIT. Data are for the non-institutionalized, non-elderly, non-Medicare-eligible population.

Uninsured Americans in 2022

- **Nationally**
  - In the absence of ObamaCare or RomneyCandidateCare, the number of uninsured Americans under the age of 65 is projected to rise to more than 60.0 million by 2022 (Table 6).
  - Under ObamaCare, the number of uninsured Americans would *decrease* significantly, falling by 32.9 million by 2022 (Table 6).
  - In sharp contrast, under RomneyCandidateCare, the number of uninsured Americans would actually *increase*, rising by nearly 18.0 million to 78.0 million by 2022 (Table 7).
  - Under RomneyCandidateCare, in 2022, there would be nearly 50.9 million more uninsured people than under ObamaCare (Table 7).
- **By State** (Table 6)
  - In **Colorado**
    - Under ObamaCare, 410,000 people would gain health coverage by 2022.
    - Under RomneyCandidateCare, 290,000 people would lose health coverage by 2022.
  - In **Florida**
    - Under ObamaCare, 2,640,000 people would gain health coverage by 2022.
    - Under RomneyCandidateCare, 930,000 people would lose health coverage by 2022.
  - In **Iowa**
    - Under ObamaCare, 230,000 people would gain health coverage by 2022.
    - Under RomneyCandidateCare, 170,000 people would lose health coverage by 2022.
  - In **Michigan**
    - Under ObamaCare, 960,000 people would gain health coverage by 2022.
    - Under RomneyCandidateCare, 620,000 people would lose health coverage by 2022.
  - In **Nevada**
    - Under ObamaCare, 330,000 people would gain health coverage by 2022.
    - Under RomneyCandidateCare, 110,000 people would lose health coverage by 2022.

Table 6.

Uninsured People under the Age of 65, by State, 2022

State	Baseline Number Of Uninsured*	Change in Number of Uninsured	
		ObamaCare	RomneyCandidateCare
Alabama	830,000	-520,000	+270,000
Alaska	150,000	-100,000	+30,000
Arizona	1,550,000	-860,000	+390,000
Arkansas	640,000	-430,000	+200,000
California	8,580,000	-4,330,000	+3,160,000
Colorado	800,000	-410,000	+290,000
Connecticut	450,000	-190,000	+200,000
Delaware	120,000	-60,000	+60,000
District of Columbia	90,000	-30,000	+70,000
Florida	4,580,000	-2,640,000	+930,000
Georgia	2,280,000	-1,350,000	+330,000
Hawaii	120,000	-50,000	+70,000
Idaho	350,000	-240,000	+80,000
Illinois	2,280,000	-1,240,000	+730,000
Indiana	1,020,000	-670,000	+370,000
Iowa	440,000	-230,000	+170,000
Kansas	430,000	-240,000	+140,000
Kentucky	780,000	-430,000	+190,000
Louisiana	1,100,000	-660,000	+270,000
Maine	150,000	-100,000	+80,000
Maryland	900,000	-400,000	+280,000
Massachusetts	470,000	-130,000	+310,000
Michigan	1,530,000	-960,000	+620,000
Minnesota	610,000	-280,000	+330,000
Mississippi	750,000	-470,000	+130,000
Missouri	1,010,000	-640,000	+260,000
Montana	210,000	-140,000	+40,000
Nebraska	290,000	-160,000	+80,000
Nevada	670,000	-330,000	+110,000
New Hampshire	160,000	-80,000	+50,000
New Jersey	1,590,000	-920,000	+500,000
New Mexico	520,000	-280,000	+70,000
New York	3,670,000	-1,550,000	+1,630,000
North Carolina	1,920,000	-1,030,000	+480,000
North Dakota	100,000	-60,000	+30,000
Ohio	1,850,000	-1,110,000	+810,000
Oklahoma	750,000	-470,000	+140,000
Oregon	740,000	-450,000	+190,000
Pennsylvania	1,650,000	-910,000	+790,000
Rhode Island	140,000	-80,000	+60,000
South Carolina	1,110,000	-690,000	+230,000
South Dakota	130,000	-90,000	+30,000
Tennessee	1,100,000	-590,000	+330,000
Texas	7,410,000	-3,910,000	+1,140,000
Utah	470,000	-260,000	+90,000
Vermont	70,000	-30,000	+50,000
Virginia	1,310,000	-820,000	+250,000
Washington	1,140,000	-680,000	+340,000
West Virginia	300,000	-200,000	+120,000
Wisconsin	630,000	-370,000	+400,000
Wyoming	110,000	-70,000	+30,000
U.S. Total	**60,020,000**	**-32,930,000**	**+17,950,000**

Source: Estimates prepared for Families USA by Jonathan Gruber, MIT. Data are for the non-institutionalized, non-elderly, non-Medicare-eligible population.

*The baseline number of uninsured is the number of people who would be uninsured in 2022 in the absence of any of the reforms that are described in this analysis.

- In **New Hampshire**
  - Under ObamaCare, 80,000 people would gain health coverage by 2022.
  - Under RomneyCandidateCare, 50,000 people would lose health coverage by 2022.
- In **North Carolina**
  - Under ObamaCare, 1,030,000 people would gain health coverage by 2022.
  - Under RomneyCandidateCare, 480,000 people would lose health coverage by 2022).
- In **Ohio**
  - Under ObamaCare, 1,110,000 people would gain health coverage by 2022.
  - Under RomneyCandidateCare, 810,000 people would lose health coverage by 2022.
- In **Pennsylvania**
  - Under ObamaCare, 910,000 people would gain health coverage by 2022.
  - Under RomneyCandidateCare, 790,000 people would lose health coverage by 2022.
- In **Virginia**
  - Under ObamaCare, 820,000 people would gain health coverage by 2022.
  - Under RomneyCandidateCare, 250,000 people would lose health coverage by 2022.
- In **Wisconsin**
  - Under ObamaCare, 370,000 people would gain health coverage by 2022.
  - Under RomneyCandidateCare, 400,000 people would lose health coverage by 2022.

Table 7.

Difference in Non-Elderly Uninsured under ObamaCare and RomneyCandidateCare, 2022

	ObamaCare	RomneyCandidateCare
Baseline Uninsured	60,020,000	60,020,000
Change	-32,930,000	+17,950,000
Total Uninsured	27,090,000	77,970,000

Difference 50,880,000

Source: Estimates prepared for Families USA by Jonathan Gruber, MIT. Data are for the non-institutionalized, non-elderly, non-Medicare-eligible population.

Medicare Preventive Health Care Services

- ObamaCare provides free preventive health care services, such as colonoscopies and mammograms, to seniors and people with disabilities enrolled in Medicare. In 2011, 25.7 million beneficiaries who were enrolled in traditional Medicare (fee-for-service Medicare) received one or more free preventive services (Table 8).
- Under RomneyCandidateCare, Medicare would no longer provide preventive services for free, and cost-sharing would be reinstated. The millions of seniors and people with disabilities who currently receive free services would have to pay cost-sharing, such as copayments and co-insurance, for such care.

Table 8.

Traditional Medicare Beneficiaries Receiving Free Preventive Services under ObamaCare, 2011

State	Number	Percent	State	Number	Percent
Alabama	501,100	72.8%	Montana	98,700	66.4%
Alaska	38,600	57.8%	Nebraska	176,800	71.3%
Arizona	421,300	69.9%	Nevada	161,000	64.6%
Arkansas	325,600	69.8%	New Hampshire	155,000	74.3%
California	2,080,700	69.1%	New Jersey	876,200	76.3%
Colorado	281,800	66.9%	New Mexico	149,300	64.0%
Connecticut	343,900	77.0%	New York	1,490,700	74.0%
Delaware	114,400	77.2%	North Carolina	980,900	76.6%
District of Columbia	43,900	67.3%	North Dakota	71,400	72.1%
Florida	1,824,700	75.8%	Ohio	922,400	72.7%
Georgia	722,800	72.3%	Oklahoma	361,700	69.4%
Hawaii	77,100	68.9%	Oregon	248,400	67.1%
Idaho	110,200	65.1%	Pennsylvania	1,014,400	73.6%
Illinois	1,245,000	74.4%	Rhode Island	85,400	76.2%
Indiana	619,700	73.1%	South Carolina	509,300	74.7%
Iowa	348,400	76.4%	South Dakota	89,100	71.1%
Kansas	281,600	72.4%	Tennessee	603,000	73.5%
Kentucky	470,500	72.7%	Texas	1,790,900	72.7%
Louisiana	376,000	70.9%	Utah	124,800	68.0%
Maine	167,500	72.4%	Vermont	77,900	72.3%
Maryland	528,200	74.9%	Virginia	737,000	75.1%
Massachusetts	656,100	77.6%	Washington	499,200	68.5%
Michigan	983,300	75.1%	West Virginia	212,900	70.3%
Minnesota	306,900	70.6%	Wisconsin	477,800	74.0%
Mississippi	325,300	69.9%	Wyoming	46,900	60.0%
Missouri	582,600	73.2%	**U.S. Total**	**25,721,000**	**73.3%**

Source: Department of Health and Human Services, *The Affordable Care Act: Strengthening Medicare in 2011* (Washington: CMS, 2012), available online at http://www.cms.gov/apps/files/MedicareReport2011.pdf.

- By state, the number of seniors and people with disabilities who received free Medicare preventive care services in 2011 under ObamaCare and who would lose them under RomneyCandidateCare are as follows (Table 8):
  - In Colorado, 281,800 seniors and people with disabilities.
  - In Florida, 1,824,700 seniors and people with disabilities.
  - In Iowa, 348,400 seniors and people with disabilities.
  - In Michigan, 983,300 seniors and people with disabilities.
  - In Nevada, 161,000 seniors and people with disabilities.
  - In New Hampshire, 155,000 seniors and people with disabilities.
  - In North Carolina, 980,900 seniors and people with disabilities.
  - In Ohio, 922,400 seniors and people with disabilities.
  - In Pennsylvania, 1,014,400 seniors and people with disabilities.
  - In Virginia, 737,000 seniors and people with disabilities.
  - In Wisconsin, 477,800 seniors and people with disabilities.

Medicare Prescription Drug Coverage

- Prior to ObamaCare, Medicare's prescription drug benefit had a huge coverage gap that is euphemistically called the doughnut hole. In 2012, that coverage gap begins once a Medicare beneficiary reaches $2,930 in drug expenses, and it continues until that beneficiary reaches $6,657.50 in drug expenses—a gap of $3,727.50. With each passing year, that gap grows.
- Under ObamaCare, this coverage gap is being phased out, and people enrolled in Medicare drug coverage are already being helped today:
  - Since 2010, when help with the doughnut hole began, ObamaCare has saved seniors and people with disabilities enrolled in Medicare more than $4.1 billion.[6]
  - In 2011, nearly 3.8 million Medicare beneficiaries received discounts of 50 percent on the cost of brand-name drugs while in the doughnut hole, an average of $613 per person (Table 9).
  - By 2020, under ObamaCare, the drug coverage gap will be entirely eliminated.[7]
- Under RomneyCandidateCare, seniors and people with disabilities in Medicare would no longer receive help with prescription drug costs while in the doughnut hole. The millions of people who currently receive help with high drug costs would lose that help.
- By state, the number of people who fell into the doughnut hole in 2011, who received help under ObamaCare but who would lose it under RomneyCandidateCare, are as follows (Table 9):

Table 9.

Medicare Beneficiaries Receiving Help with Prescription Drug Costs under ObamaCare, 2011

State	Number	Total Help	Average Help
Alabama	53,200	$31,800,200	$598
Alaska	2,400	$1,694,100	$715
Arizona	69,500	$39,368,700	$566
Arkansas	35,900	$21,117,900	$589
California	335,600	$182,323,800	$543
Colorado	41,800	$24,373,200	$583
Connecticut	39,900	$26,302,200	$659
Delaware	13,000	$9,996,300	$769
District of Columbia	2,600	$1,645,200	$626
Florida	253,000	$151,807,700	$600
Georgia	107,900	$62,420,800	$578
Hawaii	22,000	$7,284,400	$331
Idaho	15,700	$9,200,200	$584
Illinois	150,700	$101,750,500	$675
Indiana	93,800	$61,493,900	$655
Iowa	44,500	$27,626,000	$621
Kansas	40,900	$24,973,400	$610
Kentucky	78,700	$43,325,100	$551
Louisiana	55,800	$32,331,600	$579
Maine	12,600	$6,771,700	$536
Maryland	55,000	$32,779,200	$596
Massachusetts	65,800	$39,309,300	$597
Michigan	87,900	$51,336,900	$584
Minnesota	61,600	$36,585,000	$594
Mississippi	35,400	$21,453,400	$606
Missouri	82,600	$49,654,300	$601
Montana	11,100	$6,868,800	$621
Nebraska	25,500	$16,147,100	$634
Nevada	23,500	$13,112,000	$557
New Hampshire	13,900	$8,769,800	$631
New Jersey	131,400	$100,469,500	$765
New Mexico	19,500	$9,782,000	$501
New York	247,800	$175,002,400	$706
North Carolina	113,300	$68,862,400	$608
North Dakota	10,600	$6,338,400	$598
Ohio	197,100	$103,048,800	$523
Oklahoma	56,500	$30,248,800	$535
Oregon	47,200	$25,227,400	$534
Pennsylvania	242,900	$162,667,400	$670
Rhode Island	15,500	$8,611,800	$556
South Carolina	55,800	$34,750,800	$623
South Dakota	11,500	$7,141,900	$620
Tennessee	87,800	$52,323,500	$596
Texas	221,000	$142,414,600	$644
Utah	22,000	$13,112,500	$595
Vermont	7,100	$5,107,500	$720
Virginia	86,000	$52,667,500	$612
Washington	63,300	$38,097,900	$601
West Virginia	37,400	$26,016,900	$695
Wisconsin	62,800	$40,525,500	$645
Wyoming	5,900	$3,764,200	$643
U.S. Total	**3,768,800**	**$2,311,289,600**	**$613**

Source: Department of Health and Human Services, Centers for Medicare and Medicaid Services estimates of Medicare beneficiaries receiving prescription drug discounts while in the Part D doughnut hole during the 2011 plan year. U.S. total exceeds sum of states because of services received in the U.S. territories. Data are available online at https://www.cms.gov/Plan-Payment/.

- In Colorado, 41,800 seniors and people with disabilities received drug discounts.
- In Florida, 253,000 seniors and people with disabilities received drug discounts.
- In Iowa, 44,500 seniors and people with disabilities received drug discounts.
- In Michigan, 87,900 seniors and people with disabilities received drug discounts.
- In Nevada, 23,500 seniors and people with disabilities received drug discounts.
- In New Hampshire, 13,900 seniors and people with disabilities received drug discounts.
- In North Carolina, 113,300 seniors and people with disabilities received drug discounts.
- In Ohio, 197,100 seniors and people with disabilities received drug discounts.
- In Pennsylvania, 242,900 seniors and people with disabilities received drug discounts.
- In Virginia, 86,000 seniors and people with disabilities received drug discounts.
- In Wisconsin, 62,800 seniors and people with disabilities received drug discounts.

Summary of Sources for Key Findings

In order to compare ObamaCare, RomneyCare, and RomneyCandidateCare, Families USA commissioned the work of Dr. Jonathan Gruber, Professor of Economics at the Massachusetts Institute of Technology. Dr. Gruber's economic model, built on publicly available data, allowed us to generate unique new estimates of the impact of each of these three policy approaches on the following: the number of people eligible for help with the cost of health insurance premiums and the value of that help, the average amount of money spent on health care by people with private insurance, and the number of uninsured people. (A detailed Methodology is available upon request.) For our analysis of the new prevention and prescription drug benefits for Medicare enrollees that are part of the Affordable Care Act, we relied on the most recent annual Medicare data from the Centers for Medicare and Medicaid Services. These data are based on Medicare claims data for 2011. State-level data on the Medicare prevention and prescription drug benefits are available on the federal government's website at www.HealthCare.gov.

ObamaCare versus RomneyCare versus RomneyCandidateCare

	ObamaCare	RomneyCare	RomneyCandidateCare
People with Pre-Existing Conditions			
Protect against denials of coverage?	Yes	Yes	No[a]
Protect against high premiums?	Yes	Yes	No
Women			
Prohibit higher premiums based only on gender?	Yes	Yes	No
Eliminate deductibles and copays for preventive services?	Yes	Yes[b] (Deductibles only)	No
Young Adults			
Allow to stay on parent's plan?	Yes, to age 26	Yes, to age 25[c]	No[d]
Small Business Owners			
Give tax credits for providing insurance to workers?	Yes	No	No
Create new insurance marketplace with new plan choices?	Yes	Yes	No
Private Insurance Consumer Protections			
Ban annual or lifetime caps on coverage?	Yes	Yes[e] (Annual caps only)	No
Require insurance companies to spend at least 80% of premiums on health care?	Yes	Yes	No
Create new insurance marketplace with new plan choices?	Yes	Yes	No
Require uniform and clear information about plans?	Yes	Yes (Only in Connector)	Unclear[f]
Limit out-of-pocket health care spending?	Yes	Yes (Only in Connector)	No
Require preventive care with no copays?	Yes	No	No
Help with the Cost of Private Insurance			
Provide subsidies on a sliding scale based on income?	Yes, to 4 times poverty level	Yes, to 3 times poverty level	No
Average size of subsidy for working families?	$4,231	$6,292	$2,490
Help for Low-Income Families and Individuals			
Increase/decrease federal dollars to states for health coverage?	Increases	n/a	Decreases
Protect coverage for low-income children?	Yes	Yes	No
Protect coverage for people in long-term care?	Yes	n/a	No
Change in Number of Uninsured Americans			
2016	- 30,700,000	- 29,640,000	+11,160,000
2022	- 32,930,000	- 33,990,000	+17,950,000
Seniors and Other Medicare Beneficiaries			
Eliminate deductibles and copays for preventive services?	Yes	n/a	No
Provide help with cost of prescription drugs?	Yes	n/a	No
Protect Medicare's guarantee of benefits?	Yes	n/a	No
Fund efforts to improve cost and quality in Medicare?	Yes	n/a	No
Extend life of Medicare trust fund?	Yes, by 8 yrs.	n/a	No[g]

Notes for Comparison Table

[a] Although Governor Romney has clearly and repeatedly stated that he will repeal all of ObamaCare, on September 9, 2012, during his appearance on the television program *Meet the Press*, Governor Romney said, "Well, I'm not getting rid of all of healthcare reform. Of course, there are a number of things I like in healthcare reform that I'm going to put in place. One is to make sure that those with pre-existing conditions can get coverage." (See http://www.msnbc.msn.com/id/48959273/ns/meet_the_press-transcripts/t/september-mitt-romney-ann-romney-julian-castro-peggy-noonan-ej-dionne-bill-bennett-chuck-todd/#.UE0xsq6x5io.) Reporters quickly asked the governor for clarification. Katrina Trinko posted on *The Corner* blog in *National Review Online* (see http://www.nationalreview.com/corner/316367/re-romney-and-obamacare-katrina-trinko) that a Romney aide responded to her question about the governor's position on pre-existing condition protections by referring her to remarks that he made in a campaign speech on June 11, 2012, in Orlando, Florida: "I don't want them to be denied insurance because they have some pre-existing condition, so we're going to have to make sure that the law we replace ObamaCare with assures that people who have a pre-existing condition, *who've been insured in the past*, are able to get insurance in the future so they don't have to worry about that condition keeping them from getting the kind of health care they deserve" [emphasis added]. (See http://www.c-span.org/Events/Mitt-Romney-Campaigns-in-Florida/10737431506/.) And the Romney campaign website, under the heading "Mitt's Plan" in the health care section, indicates that he seeks to "Prevent discrimination against individuals with pre-existing conditions *who maintain continuous coverage*" [emphasis added], although there is no information about what specific steps he will take to accomplish this (see http://www.mittromney.com/issues/health-care). Under existing federal law, people who lose or leave job-based coverage and who have been insured for at least 18 months have a right to buy certain other policies regardless of their pre-existing conditions, but these designated policies can be very expensive. People whose last coverage was through an individual or public plan do not yet have similar rights. This will change under ObamaCare in 2014. It is unclear if Governor Romney would go beyond current law to protect people with pre-existing conditions. He has not clearly stated his policy position on the scope of protections for people with pre-existing conditions who have had continuous coverage. (He would not provide protections to people with any gap in coverage.) The governor has not clarified whether he would protect people with pre-existing conditions from denials of coverage, from being charged higher premiums, and from having insurance plans add riders that exclude coverage of their pre-existing conditions. ObamaCare provides all three of these protections, which are necessary to completely eliminate discrimination against people with pre-existing conditions in the individual, non-group private insurance market.

[b] RomneyCare required that the Connector Board and the Insurance Division define "minimum creditable coverage," a standard for all plans in the Connector and for most plans sold outside the Connector. In 2009, they set a requirement that plans must cover, at a minimum, three preventive care visits for individuals or six for families.

[c] For two years, or until the young adult turns 25.

[d] Governor Romney has indicated that he would repeal the entire Affordable Care Act. However, when he appeared on *Meet the Press* on September 9, 2012, he stated that he hopes "… the marketplace allows for individuals to have policies that cover their—their family up to whatever age they might like." As of this writing, Governor Romney has not proposed any specific policies to this end.

[e] When the Connector Board and the Insurance Division defined "minimum creditable coverage" in 2009, they prohibited all plans in the Connector and most plans sold outside the Connector from imposing annual benefit limits on core essential services.

[f] Governor Romney stated on May 12, 2011, in a speech at the University of Michigan, "I like the idea of a *Consumer Reports*-type approach where *Consumer Reports* itself or others like it would rank programs around the country and which ones provide the best coverage for the best value." See http://www.cspanvideo.org/appearance/599967915.

[g] Governor Romney has indicated that he will repeal all of the provisions of ObamaCare, including all the provisions in the law that extend the life of the Medicare trust fund.

Discussion

Comparing ObamaCare to RomneyCare to RomneyCandidateCare

Very different approaches to—and visions for—America's health care system are receiving, and deserve to receive, significant attention. The presidential candidates' positions on health reform present stark differences. President Obama's record of passing the Affordable Care Act contrasts with Governor Romney's call to repeal the law and to make fundamental changes to the Medicare and Medicaid programs.

Our report presents new, unique, national and state-by-state data illustrating the effects of the Affordable Care Act and the very different impact of Republican presidential candidate Romney's health care proposals if they were in place nationally.

Our analysis uses three criteria to measure the effect of each health reform approach:

1. The number of people who would be eligible for help with the cost of health insurance premiums and the value of that help,
2. The average amount of money spent on health care by people with private insurance, and
3. The number of uninsured people.

Our report also looks at the new preventive and prescription drug benefits for Medicare enrollees that were passed as part of the Affordable Care Act. These benefits would be repealed by Governor Romney.

President Obama's health care platform has been clearly spelled out in the provisions contained in the health care law that he fought to pass and signed into law on March 10, 2010, *The Patient Protection and Affordable Care Act*. For purposes of this analysis, we assumed full implementation of all the provisions of the law (which we refer to as ObamaCare) in 2016, including the full Medicaid expansion in all states.

To understand Governor Romney's health care platform, we first looked at his record as Governor of Massachusetts and the provisions of the law he signed on April 12, 2006 (which we refer to as RomneyCare), as well as subsequent steps taken to implement the law under the authority of the Board of the Massachusetts Commonwealth Health Insurance Connector Authority. We modeled what RomneyCare would look like if key provisions of that law were in place nationwide (Table 1).

We then turned to examine the specific proposals that Governor Romney has articulated as a presidential candidate. We have been careful to model the impact of positions that we can clearly link to Candidate Romney (which we refer to as RomneyCandidateCare). We have not attempted to model general policy statements. For example, while the discussion below includes information about pre-existing condition protections in ObamaCare and RomneyCare, we do not have sufficient detail to describe, or model, protections for people with pre-existing conditions in RomneyCandidateCare.

The following sections provide descriptions of the relevant specific provisions of ObamaCare (see below), RomneyCare (see page 30), and RomneyCandidateCare (see page 33). For our analysis, we looked at 2016, the last year of the next president's term in office, and assumed full implementation of the law's key provisions. For the number of uninsured, we look at both 2016 and 2022 in order to demonstrate how the gap in the number of Americans without health coverage under ObamaCare and RomneyCandidateCare grows over time.

These descriptions are followed by a discussion of the candidates' positions on Medicare (see page 37).

ObamaCare: The Affordable Care Act

- **State Health Insurance Marketplaces—Exchanges**

  ObamaCare requires the establishment of state health insurance "exchanges" that, beginning in 2014, will provide marketplaces with strong consumer protections where individuals, families, and small businesses can choose from a range of health insurance plans. In the new exchanges, insurance companies will have to clearly explain what care is covered and at what cost. This will help people shop for the best plan for the price, and it will promote competition among plans. Depending on consumers' incomes, they may qualify for a premium tax credit to help defray the cost of coverage (described in more detail on page 24).

  States may elect to operate their own state exchange, to enter into agreements with other states to jointly provide an exchange, to partner with the federal government to run an exchange in the state, or to leave it to the federal government to run an exchange in the state. Some of the duties of an exchange include the following: certifying plans as being qualified to sell in the exchange, maintaining a website to help people compare standardized plans, helping people determine their eligibility for Medicaid or other public programs, helping them calculate available premium tax credits, and establishing "navigator" programs that will make grants to community-based organizations and other entities to provide outreach and to help people enroll in coverage.

Only plans that meet certain qualifications will be allowed to sell health insurance to individuals and small businesses in the exchanges. To qualify, these plans must cover an essential benefits package, which will provide varying levels of coverage, labeled "bronze," "silver," "gold," and "platinum." These levels refer to the percentage of the costs that will be paid for by the plan: A bronze plan will pay for 60 percent of the cost of covered benefits, a silver plan will pay for 70 percent, a gold plan will pay for 80 percent, and a platinum plan will pay for 90 percent. In addition, plans will be allowed to offer a lesser level of coverage to individuals under the age of 30 who purchase coverage. Qualified plans must limit enrollees' out-of-pocket costs for covered services (including deductibles). These out-of-pocket spending caps are described below.

- **Consumer Protections for Private Insurance**

  ObamaCare created new processes to review health insurance premium rates that require insurance companies to clearly explain how they set premiums and that also require states to have robust rate review systems in which they can reject unreasonable premium rates or requests for increases. The law has already provided federal grants to states to strengthen their capacity to review health insurance premiums and requests for increases. If a state and the Secretary of Health and Human Services (HHS) find premium increases to be unreasonable, they can bar a plan from participating in an exchange.

  ObamaCare also created new standards governing the percentage of premium dollars that must be spent on health care services rather than going to insurance company profits, CEO salaries, or other overhead. Health plans must already meet such medical loss ratio (MLR) standards. These standards require plans to account for their expenses in the following three categories: medical and clinical costs, expenditures to improve the quality of care, and all other costs. If a plan has not spent an adequate share of premium dollars on the first two categories of expenses (80 percent for individual and small group plans, 85 percent for large group plans), the plan is required to pay rebates to enrollees. On June 1, 2012, the first round of rebate checks from insurance companies that didn't meet the MLR requirements was mailed to 12.8 million Americans with a total value of more than $1.1 billion (the average rebate per household was $151).[8]

- **New Premium Tax Credits**

  ObamaCare offers new financial assistance to low- and middle-income individuals and families that will be provided through a new tax credit to subsidize the cost of health insurance premiums. These new premium tax credits, which will offset a significant portion of the cost of health insurance premiums, will be calibrated to ensure that individuals and families do not have to spend an excessive share of their income on premiums. The limit on how much each family will pay for exchange coverage will be between 2 and 9.5 percent of income, based on a sliding scale.[9]

Generally, the premium tax credits will be available to individuals and families who have incomes between 133 and 400 percent of poverty (between about $15,000 and $45,000 for an individual, and about $31,000 and $92,000 for a family of four) to help with the cost of premiums for coverage that is purchased through the new exchanges. People who have an offer of coverage from their employer may also be eligible for a premium tax credit for coverage through an exchange if they would have to pay more than 9.5 percent of their income for their employer's plan, or if their employer's plan pays less than 60 percent of the cost of covered benefits.

While ObamaCare will deliver the premium subsidy through a tax credit, technically, this financial help will not work like other tax credits: Families with low incomes who do not owe taxes will still receive subsidies to assist with the cost of premiums. In addition, families will not need to wait until their taxes have been filed and processed in order to receive the subsidy and enroll in coverage. Instead, the subsidy will be available to pay the premium at the time the person enrolls in a plan.

The new premium tax credits will provide assistance to *insured* individuals and families who struggle to pay rising premiums, as well as to *uninsured* individuals and families who need help to be able to purchase coverage. In fact, more than half of the individuals and families who will be eligible for these tax credits will already have insurance. Among all the people who will be eligible for the tax credits, two-thirds will be in working families with annual incomes at or above 200 percent of poverty (about $46,000 for a family of four). More than half of those who will be eligible for the premium tax credits will be workers at small businesses with fewer than 100 employees.[10]

- **New Protections on Out-of-Pocket Spending**

  Over the last two decades, health care spending has risen rapidly, driving an increase in insurance premiums. In reaction to rising premiums, employers and consumers have been forced to try to hold down premium costs by moving to skimpier health insurance plans—plans that cover fewer benefits, that pay a smaller share of the benefits they do cover, or that limit how much the insurer pays for health care. As a result, even for those with insurance, a growing portion of the family budget is spent on out-of-pocket health care costs. ObamaCare includes three provisions that protect individuals and families from high out-of-pocket spending:

  1. It eliminates lifetime and annual limits on how much a health insurance plan will pay for covered benefits so that plan payments don't abruptly "run out."
  2. It caps how much a person must spend each year on deductibles and copayments for covered benefits.
  3. It provides additional help to lower-income families in the form of cost-sharing subsidies to further reduce their out-of-pocket spending on deductibles and copayments.

1. Lifetime and Annual Limits

Under ObamaCare, insurance companies will no longer be allowed to set limits on the dollar amount of health benefits that they will cover in a single year or over the course of a person's lifetime. This means that consumers who pay for health coverage won't run out of coverage if they develop a health problem that is costly to treat.

The annual limits protection is being phased in between 2010 and 2014. Today, the law mandates that all job-based plans and individual health insurance plans cannot set an annual limit that is lower than $2 million. The law does away with these limits entirely in 2014.

These protections apply to "essential benefits." Essential benefits include the following: ambulatory care, such as doctor and specialist visits; emergency services; hospitalization; preventive and wellness services and chronic disease management; laboratory services; prescription drug coverage; maternity and newborn care; pediatric services; mental health and substance use disorder services; and rehabilitative and habilitative services and devices.

The *lifetime limit* protection applies to all insurance plans. The *annual limit* protection applies to everyone who gets coverage through his or her job and to people who purchase a new individual or family plan after March 23, 2010. The protection may also apply to plans purchased before March 23, 2010, if the plan has made major changes in its coverage or substantially increased its cost-sharing or deductibles.[11]

2. Caps on Out-of-Pocket Spending

ObamaCare also establishes sliding-scale caps on out-of-pocket spending for health services that are included in the law's essential benefits package. This means that the amount an insured individual or family has to spend on deductibles, copayments, and co-insurance is capped.

The law initially set the level of these new caps by tying them to an existing definition: the annual out-of-pocket spending limits for high-deductible health plans that are associated with health savings accounts (HSAs). If these caps went into effect in 2012, they would be $6,050 for individuals and $12,100 for families.

ObamaCare will further reduce these out-of-pocket caps for families with incomes below 400 percent of poverty (about $92,000 for a family of four) who purchase coverage in the exchanges. If they were in effect in 2012, the caps would be reduced on a sliding scale as follows:

- Income between 100 and 200 percent of poverty: cap of $2,017 per individual and $4,033 per family;
- Income between 200 and 300 percent of poverty: cap of $3,025 per individual and $6,050 per family;
- Income between 300 and 400 percent of poverty: cap of $4,033 per individual and $8,067 per family.[12]

3. Cost-Sharing Subsidies

In addition to premium tax credits and caps on out-of-pocket spending, ObamaCare provides cost-sharing subsidies to individuals and families with incomes below 250 percent of poverty (about $58,000 for a family of four) who purchase a silver level plan through the new state exchanges. These cost-sharing subsidies will increase the percentage of total health care costs that their plans pay for.

Protections for People with Pre-Existing Conditions

Millions of Americans have pre-existing conditions such as diabetes, heart disease, and cancer. Under ObamaCare, beginning in 2014, insurance companies will no longer be allowed to discriminate against people with pre-existing conditions by denying them coverage, charging them higher premiums, or offering them only plans that don't cover care for their conditions. (For children, some of these pre-existing condition protections took effect in 2010.) Approximately 64.8 million non-elderly Americans have been diagnosed with pre-existing conditions that frequently led to denials of coverage prior to the new law. (See Table 10 on page 28 for national and state-level estimates of the number of people with diagnosed pre-existing conditions.)

Medicaid Expansion

In addition to expanding private coverage by giving eligible people new premium tax credits, ObamaCare will increase the number of people with affordable health coverage by providing states with a new option to expand Medicaid with a higher level of federal "matching" dollars than are available under the current program.

Table 10.

Non-Elderly Americans Diagnosed with Pre-Existing Conditions that Frequently Result In Denials of Coverage, by State

State	Number	Number with a Pre-Existing Condition	Percent with a Pre-Existing Condition
Alabama	3,931,800	1,030,900	26.2%
Alaska	635,700	159,400	25.1%
Arizona	5,365,200	1,297,000	24.2%
Arkansas	2,366,600	615,600	26.0%
California	32,141,600	6,894,400	21.5%
Colorado	4,354,100	1,042,900	24.0%
Connecticut	2,992,800	742,000	24.8%
Delaware	743,200	192,300	25.9%
District of Columbia	513,100	133,700	26.1%
Florida	15,045,900	3,822,700	25.4%
Georgia	8,379,600	2,051,700	24.5%
Hawaii	1,134,000	216,300	19.1%
Idaho	1,330,300	323,000	24.3%
Illinois	10,963,100	2,853,000	26.0%
Indiana	5,474,800	1,500,600	27.4%
Iowa	2,522,700	688,200	27.3%
Kansas	2,401,800	627,200	26.1%
Kentucky	3,584,600	979,700	27.3%
Louisiana	3,641,600	929,500	25.5%
Maine	*	*	*
Maryland	4,941,900	1,198,300	24.2%
Massachusetts	*	*	*
Michigan	8,311,700	2,357,400	28.4%
Minnesota	4,510,100	1,213,300	26.9%
Mississippi	2,467,700	632,400	25.6%
Missouri	4,960,800	1,366,700	27.5%
Montana	817,300	220,000	26.9%
Nebraska	1,535,800	402,800	26.2%
Nevada	2,315,300	527,100	22.8%
New Hampshire	1,111,200	290,800	26.2%
New Jersey	*	*	*
New Mexico	1,722,900	419,900	24.4%
New York	*	*	*
North Carolina	7,974,700	2,052,100	25.7%
North Dakota	557,700	153,200	27.5%
Ohio	9,650,100	2,729,200	28.3%
Oklahoma	3,113,000	816,500	26.2%
Oregon	3,207,000	820,700	25.6%
Pennsylvania	10,425,100	2,723,600	26.1%
Rhode Island	874,800	222,700	25.5%
South Carolina	3,823,500	1,000,900	26.2%
South Dakota	677,000	189,600	28.0%
Tennessee	5,258,700	1,413,500	26.9%
Texas	21,778,600	4,893,700	22.5%
Utah	2,441,800	536,800	22.0%
Vermont	*	*	*
Virginia	6,790,100	1,675,600	24.7%
Washington	5,719,500	1,405,500	24.6%
West Virginia	1,468,000	426,800	29.1%
Wisconsin	4,794,500	1,337,700	27.9%
Wyoming	478,100	120,000	25.1%
U.S. Total	**260,045,900**	**64,821,400**	**24.9%**

Table 10 Notes:

Source: Estimates prepared by The Lewin Group for Families USA. More detail is available in Kim Bailey, *Worry No More: Americans with Pre-Existing Conditions Are Protected by the Health Care Law* (Washington: Families USA, July 2012).

Data are for the non-institutionalized, non-Medicare-eligible population.

Numbers may not add due to rounding.

* Data are not available for Maine, Massachusetts, New Jersey, New York, and Vermont because these states have laws requiring that insurers offer coverage to all people regardless of health status.

Most people do not realize that not everyone with a low income is eligible for Medicaid. In every state, children in families with incomes up to at least 200 percent of poverty (about $46,000 for a family of four) are eligible for either Medicaid or the Children's Health Insurance Program (CHIP), but the story is very different for their parents. The median upper income limit for Medicaid eligibility for parents is 64 percent of poverty (about $15,000 for a family of four). Furthermore, in most states, a childless adult can literally be penniless and not qualify for Medicaid: Only nine states currently provide any Medicaid coverage to adults without dependent children.

Beginning in 2014, states have the option to expand Medicaid to all adults with incomes at or below 133 percent of poverty (about $14,860 for an individual or $31,000 for a family of four), whether they have dependent children or not. The costs of this expanded coverage will be paid for in full by the federal government for the first three years, then that amount will gradually decline until the federal government pays 90 percent of Medicaid costs and the states pay 10 percent. This 10 percent share is much less than the share states currently pay to cover Medicaid enrollees. As more state residents gain coverage, states will be able to reduce the amount of state-only spending that goes to cover care that the uninsured receive from hospitals and safety net providers. States should then be able to achieve a net reduction in their spending on health care services.[13]

RomneyCare: The Massachusetts Health Reform Law

RomneyCare, or the health system reform that Massachusetts achieved under Governor Romney's leadership, has many similarities to ObamaCare. As described below, RomneyCare includes an exchange, called the "Health Connector," where individuals and small businesses can shop for coverage. The Health Connector is very similar to the health insurance exchanges set up in the states by the Affordable Care Act. RomneyCare includes a system of sliding-scale premium subsidies, and it establishes a process for defining minimum benefits and limits on cost-sharing. It also includes other market reforms, such as help for people with pre-existing conditions. The law expands the Medicaid program to provide coverage for low-income residents.

The 2006 Massachusetts Health Reform Law, officially called *An Act Providing Access to Affordable, Quality, Accountable Health Care*, set out the parameters of these reforms and established procedures for the state to further develope the details.

- **The Massachusetts Health Connector: A New Insurance Marketplace**

  RomneyCare established the Health Connector as the regulated marketplace where individuals and small businesses can comparison-shop for private health insurance, select the plan that best meets their needs, and enroll in coverage. Low-income adults can also get assistance on a sliding scale for their premium costs. The Health Connector is a quasi-governmental entity that has its own board and staff.

  People select coverage from the Health Connector through one of two programs: Commonwealth Choice and Commonwealth Care. People with higher incomes who are not eligible for premium assistance may purchase plans through Commonwealth Choice. Commonwealth Choice offers only plans that meet the Health Connector's seal of approval.[14] The standards require all Commonwealth Choice plans to provide high-quality coverage; to offer good value; and to offer a set of core, essential health benefits. To make it easy to compare plans online, they are grouped into three coverage tiers—gold, silver, or bronze (special plans for young adults are also available). All plans cover the same package of benefits. The tiers reflect the different copayments and deductibles and therefore have higher or lower monthly premiums.

  When small businesses purchase insurance through the Connector, they can either choose one plan or give each of their employees a choice among Commonwealth Choice plans. The Connector aggregates the employer's premium contributions and pays the plans. The Connector also helps employees pay premiums on a pre-tax basis.

RomneyCare established Commonwealth Care to insure people with incomes up to 300 percent of poverty ($33,150 for an individual or $69,150 for a family of four) who do not have coverage through their employers or through Medicaid, the Children's Health Insurance Program (CHIP), or Medicare.

- **Premium Subsidies**

  Commonwealth Care provides premium assistance to adults who purchase coverage through the private insurers that participate in the program. Under the law, people with incomes below 100 percent of poverty ($11,170 for an individual or $23,050 for a family of four) pay no premiums.

  The Massachusetts law gives the Health Connector Board the responsibility of establishing the sliding-scale premiums for Commonwealth Care and updating that scale annually.[15] Since 2008, Commonwealth Care has actually not required premium contributions for people with incomes below 150 percent of poverty. When RomneyCare first went into effect, a single person with an income at 300 percent of poverty ($33,150) paid about 5 percent of his or her income on premiums;[16] subsequent premium schedules have varied somewhat but have offered similar levels of protection.

- **Protections from High Out-of-Pocket Spending**

  RomneyCare protects people against high out-of-pocket spending in several ways. First, people with incomes below 100 percent of poverty ($11,170 for an individual or $23,050 for a family of four) are charged copayments only for prescription drugs and emergency room care; for other services, they are not required to pay any out-of-pocket costs.[17]

  Second, people with incomes between 100 and 300 percent of poverty (between $11,170 and $33,510 for an individual and $23,050 and $69,150 for a family of four) who get coverage through Commonwealth Care have limited copayments based on a sliding scale, do not have any deductibles, and their total out-of-pocket spending is capped.[18]

  Third, the bronze, silver, and gold plans that are offered through Commonwealth Choice also cap annual out-of-pocket expenses. In bronze plans, an individual with high medical costs will pay, at most, $5,000 out of pocket in a year, and a family will pay, at most, $10,000 out of pocket. In silver and gold plans, the maximum out-of-pocket expenses are lower.[19]

Fourth, the law gives the Health Connector Board the authority to establish requirements for benefits and cost-sharing for insurance plans in the Connector and for most plans outside the Connector. Using this authority, Massachusetts has limited deductibles, required people to include prescription drug and mental health coverage in their insurance plans, and banned annual limits on coverage.[20]

- **Protections for People with Pre-Existing Conditions**

  RomneyCare was built on a strong base of private insurance protections. Even prior to RomneyCare, Massachusetts insurers were not allowed to deny residents health insurance due to pre-existing conditions. RomneyCare added protections about how long people with pre-existing conditions could be made to wait before a new insurer had to cover treatment related to those conditions—that is, how long an insurer could exclude coverage for pre-existing conditions. The protections provided by RomneyCare help people in both the individual and the group market, and they go beyond the federal protections that were required at the time the Massachusetts law was enacted. Under RomneyCare, an insurer can exclude coverage of a pre-existing condition for a maximum of six months, but it cannot exclude coverage at all if the person was covered by another insurer for 18 months prior to joining the plan.[21]

- **Medicaid Expansion**

  RomneyCare expanded coverage for children and adults under MassHealth, the state's name for its CHIP and Medicaid programs. As a result, children with family incomes up to 300 percent of poverty ($69,150 for a family of four) receive subsidized coverage.[22]

  Even before RomneyCare was signed into law, Massachusetts had expanded its Medicaid program so that some childless adults with incomes below 100 percent of poverty (below $11,170 for an individual) qualified for MassHealth. (At the time, federal Medicaid funding was generally available only for coverage of children, parents, adults with disabilities, and seniors, but Massachusetts had expanded Medicaid to other adults under a Medicaid waiver.) However, prior to RomneyCare, MassHealth enrollment had closed to these childless adults; it reopened once the law went into effect.[23] As a result, childless adults can get Medicaid coverage if their incomes are below 100 percent of poverty. (They receive a benefit package called "MassHealth Essential," which covers hospital and doctor care, lab work, prescription drugs, mental health and substance abuse treatment, hearing and vision care, dental services, family planning, rehabilitative services, and medical equipment and supplies.)

- **Financing**

  To finance RomneyCare, the governor and the legislature relied heavily on the redistribution of existing funding, including federal Medicaid dollars that were previously paid directly to safety net hospitals and their health plans under a Medicaid Section 1115 waiver,[24] as well as funds from an existing state Uncompensated Care Pool. In fact, one of the factors that motivated the state to develop and pass health reform was the risk of losing $385 million in supplemental federal Medicaid payments to providers that would have been cut if the state had not redirected these Medicaid dollars to subsidies for individual coverage.

  In 1997, Massachusetts received its first Section 1115 waiver, which included additional funding for health plans operated by the safety net hospitals that provided care to a high number of uninsured patients. By 2004, the funding amounted to $385 million per year in additional payments for Massachusetts. That year, however, the federal government informed the Romney Administration that these supplemental Medicaid payments would cease after June 30, 2005.

  Governor Romney worked with the late Senator Ted Kennedy to keep these Medicaid funds for Massachusetts by agreeing to spend the money on providing coverage to lower-income uninsured residents rather than paying hospitals for treating the uninsured—through what became the Massachusetts 2006 health reform law.

RomneyCandidateCare

We conducted an extensive review of statements, press quotes and interviews, and Governor Romney's presidential campaign website to identify health care positions that relate to the three criteria we used to measure each of the health reform approaches. We identified three positions that the governor, as a presidential candidate, has clearly articulated: repealing ObamaCare; turning Medicaid into a block grant; and creating an "above-the-line" tax deduction for premiums paid for individual, non-group private insurance. While Governor Romney has mentioned other areas of the health care system that he would like to change, these policy statements were either too vague to model or would have minimal impact on the cost and availability of health coverage to consumers.

- **Repealing ObamaCare**

  Governor Romney has been emphatically critical of ObamaCare and has repeatedly stated his intention to repeal the entire law. The health care section of his campaign website states, "On his first day in office, Mitt Romney will issue an executive order that paves the way for the federal government to issue ObamaCare waivers to all 50 states. He will then work with Congress to repeal the full legislation as quickly as possible."[25]

It is clear that Governor Romney intends that, during the period we are examining, no benefits of the law will remain for health care consumers. This includes all of the ObamaCare provisions described previously, as well as the new preventive and prescription drug benefits already in place for Medicare beneficiaries. Furthermore, repealing ObamaCare would restore Medicare Advantage overpayments to insurance companies and eliminate changes in payments to providers that are designed to encourage higher-quality and more effective care. (President Obama's and Governor Romney's approaches to Medicare are described in more detail on page 37.)

- **Turning Medicaid into a Block Grant**

Not only would Governor Romney repeal the Medicaid expansion in ObamaCare, he also proposes to significantly reduce federal funds that are available to current state Medicaid programs, which would be accomplished by converting Medicaid to a block grant. The block grant would have a spending cap that would be increased each year by the Consumer Price Index (CPI) plus 1 percent—a rate of growth that's much lower than estimates of medical inflation. The spending section of his campaign website states that, as part of the governor's plan to cut federal programs, "Medicaid spending should be capped and increased each year by CPI + 1%."[26]

Medicaid currently covers 60 million Americans, half of them children.[27] For seniors and people with disabilities, it is the main source of long-term care, which Medicare does not cover. The federal government and the states jointly fund Medicaid. Under the current Medicaid program, the federal government pays between $1 and $3 for every $1 dollar a state puts into Medicaid. On average, of every dollar spent on the program today, the federal government pays 57 cents, and states pay 43 cents. This structure ensures that states have reliable federal assistance to keep up with medical inflation, as well as increased support at times when more residents turn to Medicaid for care, such as during an economic downturn, a natural disaster like a flood, or a health crisis. By turning Medicaid into a block grant, RomneyCandidateCare would fundamentally change the Medicaid program. Federal Medicaid support would no longer match state spending. Instead, the program would have a federal spending cap. Under a block grant or cap, the federal government would provide states with a set amount of money, and that amount would not change, even during an economic downturn or other circumstances that would cause more people to need Medicaid.

Over time, because the cap on Medicaid spending would be less than the historic growth in Medicaid costs, federal Medicaid support would fall farther and farther behind what it actually costs to provide health services to low-income families, children, people with disabilities, and seniors. This would shift a large percentage of Medicaid costs to states, which are already facing budget challenges, and extremely deep cuts to Medicaid would be inevitable. In fact, Governor Romney's cuts to Medicaid would threaten the future of RomneyCare and deny a key source of funding needed to replicate reforms similar to Massachusetts in other states.

- **New Income Tax Deduction**

  Governor Romney proposes to replace ObamaCare's premium tax credits for purchasing insurance in new state exchanges with a federal income tax deduction for the cost of purchasing coverage in existing private, individual, non-group insurance markets. In an Orlando speech focusing on health care, Governor Romney said, "What I would do is level the playing field and say individuals can buy insurance on the same tax advantaged status that businesses can buy insurance."[28] Individuals, then, would get the same tax deduction for health insurance premiums spent in the individual, non-group, private insurance market that employer plans currently receive.

  Unlike the ObamaCare premium subsidies, which will be delivered through a refundable tax credit that provides more help to lower-income families, RomneyCandidateCare's tax deductions provide more help to wealthier families. This is because a deduction's value is tied to the income tax bracket of the individual or family who claims the deduction. For example, a $10,000 deduction would be worth $3,500 to a higher-income family that is taxed at 35 percent but only $1,000 to a lower-income family in the 10 percent bracket. Moreover, more than half of the uninsured are too poor to owe any taxes and would see no benefit from a deduction at all.

  Furthermore, in the ObamaCare state exchanges, insurance companies would not be allowed to discriminate against people with pre-existing conditions, and the exchanges provide other new consumer protections. The RomneyCandidateCare approach appears to leave individuals and families to find insurance in the existing individual insurance markets in the states, where they often will have no offers of coverage that are affordable—or no offers at any price.

Protections for People with Pre-Existing Conditions

Governor Romney has clearly and repeatedly stated that he will repeal all of ObamaCare. However, on September 9, 2012, during an appearance on *Meet the Press*, Governor Romney said, "Well, I'm not getting rid of all of healthcare reform. Of course, there are a number of things I like in healthcare reform that I'm going to put in place. One is to make sure that those with pre-existing conditions can get coverage."[29] Reporters quickly asked the governor and his campaign for clarification. For example, on the same day that the governor made the above statement, Katrina Trinko posted on "The Corner" blog in *National Review Online*[30] that a Romney aide responded to her question about the governor's position on protecting people with pre-existing conditions by referring her to remarks that he made in a campaign speech on June 11, 2012, in Orlando, Florida: "I don't want them to be denied insurance because they have some pre-existing condition, so we're going to have to make sure that the law we replace ObamaCare with assures that people who have a pre-existing condition, *who've been insured in the past*, are able to get insurance in the future so they don't have to worry about that condition keeping them from getting the kind of health care they deserve"[31] [emphasis added]. And the Romney campaign website, under the heading "Mitt's Plan" in the health care section, indicates that he seeks to "Prevent discrimination against individuals with pre-existing conditions *who maintain continuous coverage*" [emphasis added], although there is no information about what specific steps he will take to accomplish this (see http://www.mittromney.com/issues/health-care).

Under existing federal law, people who lose or leave job-based coverage and who have been insured for at least 18 months have a right to buy certain other policies regardless of their pre-existing conditions, although these designated policies can be very expensive. People whose last coverage was through an individual or public plan do not yet have similar rights. This will change under ObamaCare in 2014.

Governor Romney has not clearly stated his policy position on the scope of protections for people with pre-existing conditions who have had continuous coverage. (He would not provide protections to people with any gap in coverage.) The governor has not clarified whether he would protect people with pre-existing conditions from denials of coverage, from being charged higher premiums, and from having insurance plans add riders that exclude coverage of their pre-existing conditions. ObamaCare provides all three of these protections, which are necessary to completely eliminate discrimination against people with pre-existing conditions in the individual, non-group private insurance market.

Changes to Medicare

Coverage for Preventive Benefits and Prescription Drugs

This report also looks at the impact of ObamaCare compared to RomneyCandidateCare on Americans who rely on Medicare. Since some of ObamaCare's key changes to Medicare are already completely or partially operational, we base our Key Findings on the most currently available reported data from the Centers for Medicare and Medicaid Services. Specifically, we include national and state-level data on the numbers of Medicare beneficiaries receiving free preventive health services under ObamaCare and receiving help in the Medicare Part D prescription drug doughnut hole.

- **Preventive Benefits**

  The most tangible difference between ObamaCare and RomneyCandidateCare for current Medicare beneficiaries is the Romney plan to repeal the new Medicare benefits that were created by ObamaCare. Since January 2011, most preventive services in Medicare have been available to all Medicare beneficiaries for free. Under the proposal to repeal ObamaCare, Medicare copayments and co-insurance for these services would be reinstated. As shown in Table 8, nearly three-fourths of Medicare beneficiaries received a free preventive service in 2011. Under RomneyCandidateCare, their out-of-pocket costs would increase.

- **Prescription Drugs**

  Medicare beneficiaries with substantial prescription drug needs would also be worse off under RomneyCandidateCare. Since its inception in 2003, the Medicare Part D prescription drug benefit has been plagued by a large and growing gap in coverage known as the doughnut hole. ObamaCare gradually closes this gap by providing discounts on drugs purchased in the doughnut hole. These discounts will increase each year until the gap is eliminated completely in 2020. In 2011, nearly 3.8 million seniors and people with disabilities received discounts on drugs. The value of these discounts averaged $613 per person and totaled more than $2.3 billion in savings for all Medicare beneficiaries. Table 9 shows the number of people with Medicare in each state who received help in the doughnut hole in 2011, as well as the average amount of savings at stake per beneficiary and the total impact in each state.

  RomneyCandidateCare would re-open the doughnut hole. This would more than double prescription drug costs for the nearly 3.8 million beneficiaries who fall into the doughnut hole each year. Moreover, under RomneyCandidateCare, out-of-pocket drug costs increase in the future. Without ObamaCare, the doughnut hole widens each year, reaching about $6,000 per person by 2020.[32]

ObamaCare and Medicare Savings

Critics of ObamaCare have frequently argued that it cuts $716 billion in Medicare benefits over the next decade. This criticism is incorrect. In fact, under ObamaCare, Medicare benefits, especially coverage of preventive care and prescription drugs, are significantly improved. Obamacare is partly funded by reducing the growth in future Medicare payments to hospitals, drug companies, and medical device manufacturers. However, these reductions in spending growth were agreed to by these health care providers because they recognized that, in totality, they would receive far more income if health reform was passed because tens of millions of uninsured Americans would gain health coverage and would then be able to pay for the medical care they received. As a result, the financial position of most health care providers would improve.

If ObamaCare is replaced by RomneyCandidateCare, the added payments to health care providers brought about through an increase in insured people would be eliminated, but the cuts in payments would not.[33] The House of Representatives budget, authored by Representative Ryan and supported by Governor Romney, would retain the same Medicare cuts as ObamaCare but would eliminate the ObamaCare programs that subsidize the purchase of private insurance and the expansion of Medicaid. The House budget also includes an additional $810 billion in cuts over 10 years to the existing Medicaid program.[34] Much of these cuts would have to come from reductions in payments to health care providers—mostly hospitals, nursing homes, and home health agencies—due to direct payment cuts, as well as a reduction in the number of patients in Medicaid. In total, the health care system could see a reduction in payments of $2.3 trillion from 2013 to 2022.[35]

The impact that the Medicaid cuts would have on states and health care providers would vary depending on the state's current Medicaid eligibility rules. For example, if ObamaCare remains in place, an estimated 1.7 million people in Texas would become newly eligible for Medicaid. In Florida, this number would be 1.3 million, and in Virginia, 342,000. In contrast, if RomneyCandidateCare is passed, states like Florida and Texas would see the largest negative impact.[36]

In addition, a substantial portion of the financial support for ObamaCare is scheduled to come from reducing the overpayments to insurance companies that provide coverage to Medicare beneficiaries through the Medicare Advantage program. Before enactment of ObamaCare in 2010, federal spending for Medicare Advantage plans, on average, was 13 percent higher than was paid under traditional Medicare for the same services, with some private plans receiving substantially higher payments.[37] ObamaCare reduces these overpayments while preserving Medicare's guaranteed covered services to bring about more equity between the programs and to help pay for health reform.

Medicare's Future

- **The Medicare Trust Fund**

  Hospital care for Medicare beneficiaries is currently paid for from a trust fund that is financed by a payroll tax on all workers. The trust fund also pays for post-hospital nursing home and home health care. ObamaCare includes an increase in trust fund financing by requiring higher-income workers (individuals who earn more than $200,000 and families who earn more than $250,000) to pay an additional 0.9 percent tax on earnings and a 3.0 percent tax on unearned income. Unearned income previously was not taxed.

  The reduction in Medicare Advantage overpayments, the reduction in provider payments, and the additional federal revenues would allow the trust fund to remain solvent until 2024. Under RomneyCandidate Care, these cost savings and additional revenues would be eliminated, and the Medicare trust fund solvency date would be pushed up eight years to 2016.[38] It is unclear what would happen if the trust fund became insolvent, but it could require Medicare recipients to pay more for their care out of pocket.

- **The Structure of Medicare**

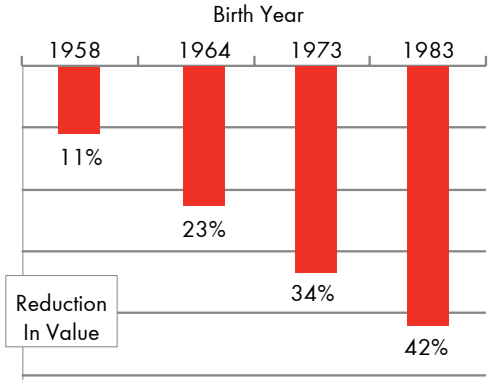
  The most fundamental difference in Medicare between ObamaCare and RomneyCandidateCare involves how the program operates in the future. ObamaCare maintains the basic structure of Medicare. The program offers a guaranteed set of benefits to everyone who qualifies. Coverage is available anywhere in the country at a uniform premium. Essential to the program's strength is that all seniors and people with disabilities join the same insurance pool. The costs of sicker beneficiaries are offset by the contributions of those who are healthier. Beneficiaries can join a private plan for their Medicare coverage, though the private plans are closely regulated and must offer coverage that is at least as good as traditional Medicare. ObamaCare seeks to slow the growth in Medicare costs over time by introducing new payment models that improve health care quality and care coordination, both in the traditional Medicare program and in private plans, resulting in healthier beneficiaries and lower costs.

  In contrast, RomneyCandidateCare relies primarily on private insurance companies to deliver health insurance for Medicare beneficiaries starting in 2023. Everyone born after 1957 would no longer be guaranteed a set of Medicare health care benefits. Instead, they would be allotted a set amount of money—a voucher—to purchase insurance. They would use these vouchers to purchase health insurance from either private health insurance plans or traditional Medicare. If the voucher were inadequate to cover the cost of the plan purchased, beneficiaries would have to pay the difference out of their own pockets.

Impact on Future Beneficiaries

Figure 1.

Cut in the Value of Medicare at Retirement Under Romney-Ryan, by Birth Year



Source: Families USA calculations based on Congressional Budget Office, *The Long-Term Budgetary Impact of Paths for Federal Revenues and Spending Specified by Chairman Ryan* (Washington: CBO, March 2012).

While Governor Romney has not provided a detailed description of his Medicare plan, he has said he supports the framework proposed in Representative Ryan's fiscal year 2013 House budget resolution. That plan would result in substantially higher health care costs for future Medicare beneficiaries for two related reasons. First, the value of the voucher is designed to shrink over time relative to what Medicare would have covered under ObamaCare. As health care costs rise, Medicare would cover less of the total. Second, private insurance companies require more money to deliver the same care as traditional Medicare because they have expenses such as marketing, advertising, commissions, administration, executive salaries, and profits. Over time, therefore, health care costs will become more expensive for Medicare beneficiaries than they would have been under existing policy.

According to the Congressional Budget Office, the fiscal year 2013 House budget proposal would result in substantial reductions in the value of Medicare coverage for future generations. As shown in Figure 1, people born in 1958 would see an 11 percent reduction in the value of their Medicare coverage the year they retire compared to what they would expect under ObamaCare. The cuts grow substantially in the future. By the time people born in 1983 reach Medicare eligibility age, their coverage would be worth 42 percent less than it would be under ObamaCare. (The fiscal year 2013 House budget proposal gradually increases the Medicare eligibility age to 67. People born in 1958 would be eligible when they turn 65 in 2023. People born in 1964 would not become eligible until they turn 66 in 2030. The increase in the eligibility age would be fully phased in by 2034. Therefore, those born in 1973 would become eligible for Medicare in 2040, and those born in 1983 would be eligible for Medicare in 2050.)

Modeling what future out-of-pocket costs will look like in dollar terms under RomneyCandidateCare is difficult because Governor Romney has not provided many key details. But in 2011, Representative Ryan proposed a similar plan as part of the fiscal year 2012 House budget resolution. According to the Congressional Budget Office, that proposal would have increased out-of-pocket costs by $6,400 per year for a 65-year-old the first year it took effect (2022), with costs increasing further in future years.

- **Risks to Current Beneficiaries**

  The drastic change to Medicare under RomneyCandidateCare would also have substantial effects on people born in 1957 or earlier, even though their coverage would ostensibly remain the same. The traditional Medicare program would become weaker and more costly over time, resulting in increased premiums as current beneficiaries age. Private plans in Medicare have always attracted younger, healthier beneficiaries, with older, sicker beneficiaries remaining in the traditional program. Private insurers are adept at designing benefit packages to appeal to younger people by offering perks like gym memberships or free basic office visits. Under the Romney plan, these plans could offset the costs of these benefits by increasing cost-sharing for services like home health care or chemotherapy, which would discourage older and sicker members from joining them.

  Although RomneyCandidateCare would presumably adjust the value of the voucher for the financial "risk" a sicker, older person presents, the process of risk adjustment is far from perfect.[39] Over time, as traditional Medicare serves a disproportionately older and sicker population, premiums in traditional Medicare will rise to cover the costs of caring for these older and sicker beneficiaries. As traditional Medicare premiums rise and more people leave the program, it will be less able to negotiate lower prices on services, which will in turn result in higher health care costs.

Conclusion

RomneyCandidateCare represents an enormous difference in the direction of health care in the United States compared to both RomneyCare and ObamaCare. As our analysis demonstrates, especially in terms of cost and coverage, RomneyCandidateCare would place a growing and unsustainable burden on America's families. That burden would make health coverage and care unaffordable for a huge portion of our nation's middle-class and moderate-income families, thereby resulting in more and more people joining the ranks of the uninsured.

RomneyCandidateCare would also signifcantly change the Medicare program that is the lifeline for America's seniors and people with disabilities. It would withdraw significant help with preventive care and prescription drug coverage that Medicare beneficiaries are already receiving through ObamaCare. It would also decrease the solvency of the Medicare trust fund. More significantly in the long run, RomneyCandidateCare would transform Medicare from a program of guaranteed benefits to a voucher-like system that would require beneficiaries to pay considerably more out of pocket for their coverage.

These are stark differences from the directions set by both RomneyCare and ObamaCare. The choice of which direction our nation will take about these fundamentally different approaches will have a profound impact on families across America.

Endnotes

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Special Thanks to:

Stuart Altman
Jonathan Gruber
John McDonough

ObamaCare versus RomneyCare versus RomneyCandidateCare

This publication is available online at
www.familiesusac4.org/2012-health-care-comparison.

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