CBO

PHOTOCOPY
PRESERVATION

PHOTOCOPY
PRESERVATION

C.B.O.

file CBO

THE WHITE HOUSE

WASHINGTON

February 7, 1994

To: Ira Magaziner
Bob Boorstin
Jeff Eller
Christine Heenan
Meeghan Prunty
John Hart
Melanne Verveer
Mike Lux

From: Chris Jennings

Re: Off-Budget Programs

The Senate Labor and Human Resources Committee prepared the attached document to illustrate all programs that are classified as off-budget. This may be helpful in the upcoming debate.

PRECEDENTS: PREMIUMS ARE NOT TAXES

HEALTH PROGRAMS

1. The Comprehensive Health Insurance Act of 1974. Nixon Administration program, introduced by Senator Packwood in the Senate, required all employers to contribute 75 per cent of the cost of coverage meeting minimum standards for employees and dependents. Mandatory premiums were not considered taxes and were off-budget.

2. Minimum Health Benefits for All Workers Act (S. 1265, 100th Congress). Under the bill, (1) All employers were required to arrange for the provision of a benefit package meeting Federal standards and contribute 80 per cent of the cost; the required benefit package was spelled out in Federal law; small employers were required to obtain their coverage through a particular category of Federally regulated insurers called "regional insurers"; employees were required to enroll and contribute to the cost of coverage. CBO formally costed this program and ruled that the mandatory premiums were off-budget and were not taxes.

3. Basic Health Benefits for All Americans Act (S. 768, 101st Congress). Relevant provisions were the same as S. 1265. CBO formally costed this program and ruled that the mandatory premiums were off-budget and were not taxes.

4. COBRA extension of coverage requirements. This legislation, enacted in 1986, requires employers to make continued health insurance coverage available to laid-off workers, divorced spouses and widows of covered workers, and adult children of covered workers. Premiums are not on-budget.

5. Workers' Compensation Insurance. Every state requires employers to purchase workers' compensation insurance to cover the health care costs and lost wages of employees injured on the job. Premiums paid for this mandatory nsurance coverage do not appear in state budgets and are not considered taxes.

6. Family and Medical Leave Act. This legislation requires employers to grant leave to employees needed at home for health or other reasons and to continue to pay their health insurance premiums during the period of

the leave. These mandatory premiums are not on-budget and are not considered taxes.

OTHER PROGRAMS MANDATING PRIVATE ACTION WITH SIGNIFICANT FINANCIAL COSTS THAT ARE NOT ON-BUDGET AND ARE NOT CONSIDERED TAXES

1. State requirements that every driver must purchase auto insurance.

2. The minimum wage requirements of the Fair Labor Standards Act regulates the wages paid by all employers not specifically exempted and imposes significant costs. In 1989 Congress increased the minimum wage from $3.35 to $4.25 an hour. The increase imposed higher wage costs on employers of $2,400 per year for each full-time worker employed at the minimum wage. The Act also imposes detailed requirements for other employer wage payments, e.g., overtime.

3. Additional laws impose mandatory requirements on specific categories of employers with regard to wages, hours, and other conditions of employment, including government contractors (Davis-Bacon, Service Contract and Walsh-Healey Acts); railroads (Railway Labor Act); and agricultural employers (Migrant and Seasonal Workers Act).

4. The Occupational Health and Safety Act requires employers to meet detailed, Federally mandated health and safety standards in the workplace and impose substantial costs. Recent standards issued under the Occupational Safety and Health Act include the Confined Spaces Standard (estimated cost of compliance: $202.4 million per year); the Lead in Construction Standard (estimated cost of compliance: $405.6 million per year); the Process Safety Management Standard (estimated cost of compliance in years 6-10: $405.8 million per year); and the Blood-Borne Disease Standard (estimated cost of compliance: $813 million per year).

5. The Clean Water Act requires localities to provide treatment for sewage meeting Federal standards. The cost of compliance under this tightly regulated Federal program is not treated as a tax and is not placed on budget, except for Federal grant funds.

6. The Clean Air Act requires states, localities, and private businesses to comply with ant-pollution standards and mandates detailed corrective

action where standards are not met. The cost of compliance is not treated as tax and is not placed on the Federal budget.

7. A whole series of agriculture programs provide for mandatory assessments on producers. These assessments are then paid to Federally chartered and approved entities, but the assessment and expenditures of these entities do not appear on the budget--because the funds are not paid into the Federal Treasury. These include: Milk marketing orders under the Agricultural Marketing Agreement Act of 1937; fifteen separate Farm Commodity Promotion Programs; and forty-three Federal Marketing Orders for Horticultural Crops.

8. Health and welfare plan requirements under the Employee Retirement and Income Security Act (ERISA), including notification, information, fiduciary responsibility, grievance and appeal procedures.

9. The requirement that private firms comply with the access standards of the Americans with Disabilities Act.

COAL INDUSTRY HEALTH RETIREES PROGRAM

The only contrary precedent that has been cited in support of classifying premiums under the Health Security Act as on-budget taxes is a retiree health program created under the "Coal Industry Health Retiree Benefits Act." But this small program for retired coal miners was created by amending the Internal Revenue Code, which, by definition, deals only with taxes.

SUMMARY

Government regulatory mandates are widespread, both in health care and in other areas. It has never been seriously suggested that the cost of such mandates should be shown on the Federal budget, unless the funds expended to comply are collected by the government, placed in the Federal Treasury, and spent by the government. Premiums under the Health Security Act meet none of these criteria.

file CBO

CBO GOOD NEWS

- **The Congressional Budget Office proved that the President's proposal will guarantee every American private health insurance while lowering health expenditures and achieving long-term deficit reduction.**
  - *"The Clinton plan, when compared to today's system, would cost average Americans less money, give them more health benefits and more choice of physicians and medial care, [Reischauer] said."* [Priest and Rich, Washington Post, 2/9/94]
  - *"The CBO credited the administration with coming up with a framework that appears to reconcile what many had considered irreconcilable: extending health care to all Americans while at the same time slowing the growth of medical costs, which threaten to consumer 20 percent of the nation's economic output by the end of the decade."* [Pearlstein and Broder, Washington Post, 2/9/94]
  - *"[The CBO analysis] is a significant acknowledgment that health reform can do what is necessary; that is, provide health coverage for all Americans while containing sky-rocketing health-care costs."* [USA Today, 2/9/94]
- **Over time, national health expenditures will be "significantly" reduced.**
  - *"Thus, CBO projects that national health expenditures would fall $30 billion below the current CBO baseline by calendar year 2000, and would be $150 billion (7 percent) below that baseline in 2004."*
  - *"Once the administration's proposal was fully implemented it would significantly reduce the projected growth of national health expenditures."* p. 26
- **Businesses will save substantially.**
  - *"But businesses' costs for health care would be significantly reduced overall . . For example, the total premiums employers would pay for active workers would drop by about $20 billion in the year 2000."* ["An Analysis of the Administration's Health Proposal", CBO, 2/9/94]
- **American workers will see higher wages.**

- *"[The Presidents proposal] would sharply reduce the growth of employer spending for health insurance. By 2004, employers would save about $90 billion for active workers and more than $15 billion for early retirees.. . the lion's share of those savings would be returned to workers in the form of higher cash wages. . . "* [*"An Analysis of the Administration's Health Proposal"*, CBO, 2/9/94, p. 35]

- *"First, the proposal would increase the cash wages of U.S. workers . . ."* [*"An Analysis of the Administration's Health Proposal"*, CBO, 2/9/94, p. 51]

WHAT ABOUT . . .

- **Reports that the CBO claims job loss . . .**
  - *"The Clinton plan, [CBO] concluded, would not significantly slow the economy or result in the loss of jobs, as many critics have charged."* [Pearlstein and Broder, Washington Post, 2/9/94]

  - *"[the proposal] would alter the unemployment rate little."* [CBO, *"An Analysis of the Administration's Health Proposal"*, 2/9/94, p.51]

The primary changes in the labor market would result would because of voluntary retirement as workers who have worked hard their whole lives no longer have to work just to be guaranteed health coverage.

- *"CBO estimates that eventually between one quarter of a percent and 1 percent of the labor force might prefer to stay at home if the proposal was enacted."* [CBO, *"An Analysis of the Administration's Health Proposal"*, 2/9/94, p. xiv]

Independet studies back this up.

- Two independent studies -- one from the Economic Policy Institute and one from the -- predict that jobs will be vcreated as a result of health reform. The EPI says that 258,000 manufacturing jobs created over the next decade. And the Employee Benefit Research Institute predicts that the President's proposal could produce as many as 660,000 jobs. [Economic Policy Institute, *"The Impact of the Clinton Health Care Plan on Jobs, Investment, Wages, Productivity, and Exports"*; EBRI, *"An Employer Mandate: What's Known and What Isn't"*, November 1993]

- **Differences in Deficit Projections**

- *"[Reischauer] also went out of his way to call the differences in financial estimates `**relatively small potatoes in the great scheme of things.**'"* [Pear, New York Times, 2/9/94]

- "Significant deficit reduction will be achieved by 2004." [UPI, 2/9/94]

- *"That $133 billion difference of opinion may have more political than economic significance: Both predict that the Clinton plan will begin saving money for the government business and consumers by the year 2000."* [Pearlstein and Broder, Washington Post, 2/9/94]

- *"Focusing on the effects of proposals in their early years is, therefore, not very meaningful; it is the long-term impacts, when new coverages would be fully phased in and the system stabilized, that are important."* [CBO, *"An Analysis of the Administration's Health Proposal"*, 2/9/94, p. xiii]

percentages??? Jamo

- **Premium Estimates Are Different . . .**
  - savings for business

What does this premium difference mean for working Americans?

- A 15% difference in premiums between the CBO and the Administration translates into about $63 a year for the average individual -- or a little more than $5 a month.

Clinton Presidential Records
Digital Records Marker

This is not a presidential record. This is used as an administrative marker by the William J. Clinton Presidential Library Staff.

This marker identifies the place of a publication.

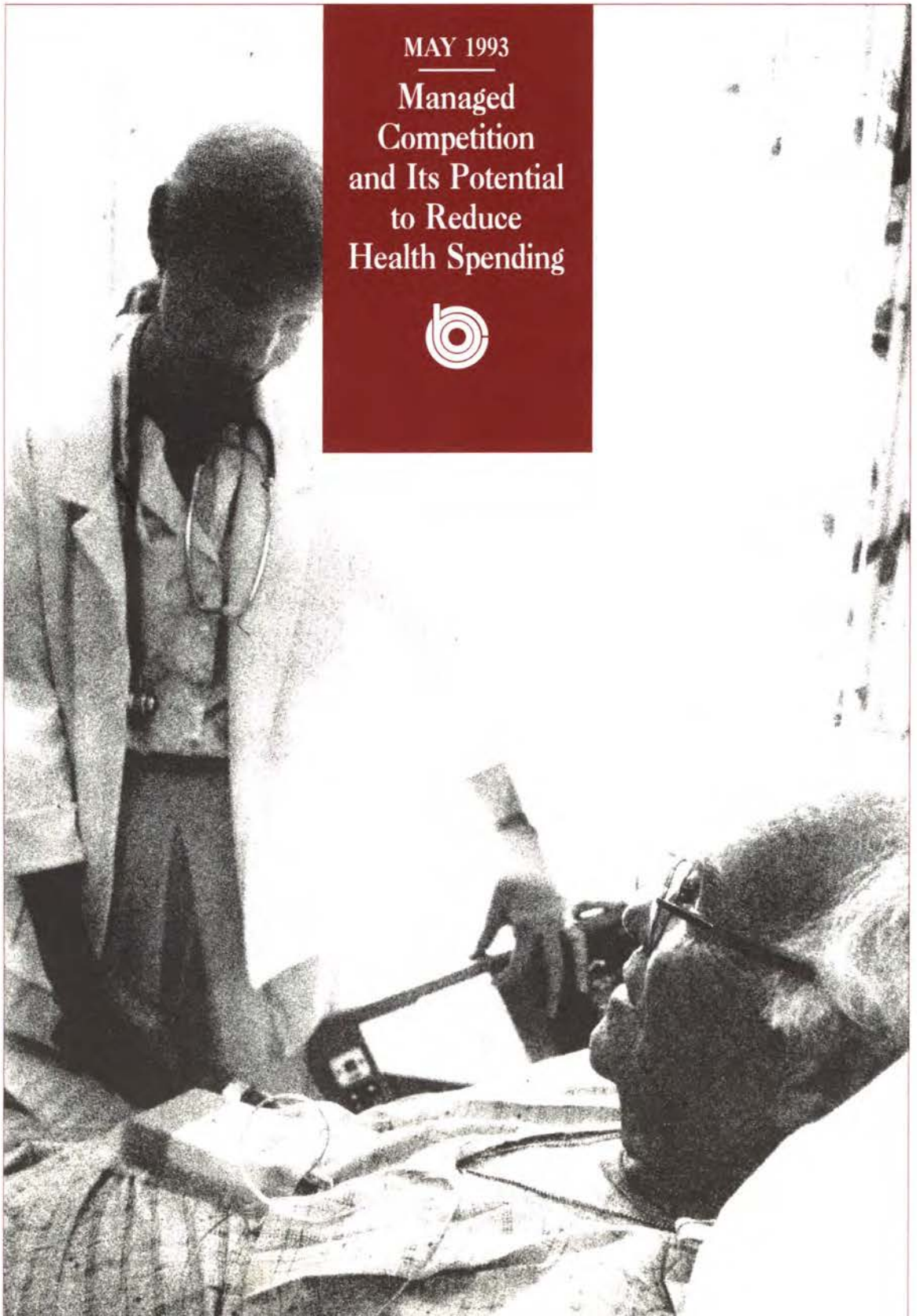
Publications have not been scanned in their entirety for the purpose of digitization. To see the full publication please search online or visit the Clinton Presidential Library's Research Room.

CONGRESS OF THE UNITED STATES
CONGRESSIONAL BUDGET OFFICE

A
CBO
STUDY

MAY 1993

Managed Competition and Its Potential to Reduce Health Spending



THE WHITE HOUSE

WASHINGTON

MEMORANDUM

To: Distribution List

From: Jack Lew

Date: June 10, 1994

Re: Preliminary C.B.O. Estimates

Attached is an official preliminary estimate by the Congressional Budget Office on the Ways and Means Mark. If you have any questions, please call me at 456–5562.

Distribution List
Pat Griffin
Harold Ickes
Ira Magaziner
Steve Ricchetti
Melanne Verveer
Roger Altman
Bob Boorstin
Jeff Eller
Greg Lawler
Chris Jennings
Nancy Ann Min
Lorrie McHugh
Alice Rivlin
Gene Sperling

CONGRESSIONAL BUDGET OFFICE
U.S. Congress
Washington, DC 20515

Robert D. Reischauer
Director

June 10, 1994

Honorable Sam M. Gibbons
Acting Chairman
Committee on Ways and Means
U.S. House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

At the request of your staff, the Congressional Budget Office (CBO) and the Joint Committee on Taxation (JCT) have prepared the enclosed estimate of your health care reform mark, as released today. Although CBO and JCT have worked closely with the staff of the committee, the estimate does not reflect detailed specifications for all provisions or final legislative language and must therefore be regarded as preliminary. Also, we have not had time to analyze the proposal's impact on employment or the economy or to review other considerations affecting the proposal's design and implementation.

Sincerely,

Robert D. Reischauer

Enclosure

cc. Honorable Bill Archer
Ranking Minority Member

H.R. 3600 - HEALTH SECURITY ACT AS AMENDED BY THE COMMITTEE ON WAYS AND MEANS - PRELIMINARY

CHAIRMAN'S MARK, JUNE 10, 1994

By fiscal year, in billions of dollars.

Estimated On-Budget Effects	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
MANDATORY OUTLAYS										
Medicaid										
1 Discontinued Coverage of Acute Care	0.0	0.0	0.0	-56.8	-84.4	-94.2	-105.0	-116.3	-128.8	-141.9
2 State Maintenance-of-Effort Payments	0.0	0.0	0.0	-39.1	-56.1	-60.1	-61.1	-65.4	-62.6	-66.9
3 Administrative Savings	0.0	0.0	0.0	-0.5	-0.7	-0.8	-0.9	-1.0	-1.1	-1.2
Total - Medicaid	0.0	0.0	0.0	-96.4	-141.2	-155.1	-167.0	-182.7	-192.5	-210.0
Medicare Parts A and B										
4 Drug Benefit (Net of Premiums and Rebate)	0.0	0.0	0.0	5.4	13.1	14.3	15.7	17.4	19.2	21.2
5 Out of Pocket Cap	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	9.4	15.4
6 Other New Benefits (Well-baby, Preventive, Mental Health, EACH/RPCH)	*	0.1	0.1	0.3	0.5	0.4	0.4	0.3	0.4	0.4
7 Additional Medicare Savings										
Indirect Medical Education	0.0	0.0	0.0	-0.3	-1.0	-1.7	-2.0	-2.2	-2.4	-2.7
Disproportionate Share Adjustment	0.0	0.0	0.0	-0.9	-2.2	-2.5	-2.8	-3.1	-3.4	-3.7
Inpatient Hospital Capital	0.0	-0.7	-0.7	-0.7	-0.8	-0.8	-0.9	-1.0	-1.1	-1.2
Pmts for Phys Svcs in Certain Hospitals	0.0	0.0	0.0	-0.5	-0.8	-0.8	-0.8	-0.9	-1.0	-1.0
Home Health Services Coinsurance	0.0	0.0	0.0	-3.0	-4.7	-5.3	-5.8	-6.2	-6.8	-7.3
Home Health Cost Limits	0.0	0.0	-0.3	-0.4	-0.5	-0.5	-0.6	-0.6	-0.7	-0.7
Medicare Secondary Payer	0.0	0.0	0.0	0.0	-1.2	-1.8	-1.9	-2.0	-2.2	-2.3
8 Minor and Technical Amendments	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
9 Part B Premium Offsets	0.0	0.3	0.7	1.5	1.8	1.8	1.9	2.0	2.0	2.2
10 Effect of Growth Limits a/	0.0	-2.7	-7.4	-14.5	-24.5	-35.2	-48.0	-63.5	-81.9	-103.6
Total - Medicare Parts A and B	0.0	-3.0	-7.5	-13.1	-20.4	-32.2	-44.7	-59.9	-68.3	-83.3
11 Federal Employees Health Benefits										
Total - FEHB	0.0	1.1	1.5	1.3	1.6	1.7	1.7	1.6	1.3	0.9
Other Health Programs										
12 Long Term Care Program	0.0	0.0	3.2	4.5	5.4	8.3	10.0	11.0	12.1	13.1
13 Academic Health Centers	0.0	1.3	2.0	1.9	2.0	0.6	0.0	0.0	0.0	0.0
14 Essential Health Facilities (Loans) b/	0.0	0.5	0.7	0.8	0.9	0.5	0.3	0.1	*	0.0
15 Federal Grants for Managed Care Plans	*	*	*	*	*	*	*	*		*
Total - Other Health Programs	0.0	1.8	5.9	7.2	8.3	9.4	10.3	11.1	12.1	13.1

H.R. 3600 - HEALTH SECURITY ACT AS AMENDED BY THE COMMITTEE ON WAYS AND MEANS - PRELIMINARY

CHAIRMAN'S MARK, JUNE 10, 1994

By fiscal year, in billions of dollars.

Estimated On-Budget Effects	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Medicare Part C										
16 Medicare Part C Start-up Premium Offset c/	0.0	0.0	0.0	6.4	9.5	8.3	5.7	1.6	0.0	0.0
17 Additional Costs of the Disabled	0.0	0.0	0.0	4.6	7.3	8.7	10.3	12.2	14.2	16.5
18 Low-Income Wrap-Around Benefits	0.0	0.0	0.0	7.7	11.2	12.1	13.1	14.1	15.2	16.4
Total - Medicare Part C	0.0	0.0	0.0	18.7	28.0	29.1	29.1	27.9	29.4	32.9
Subsidies										
Premium Subsidies:										
19 For Medicare Benes below 120% of Poverty	0.0	0.0	0.0	4.3	6.0	6.3	6.6	6.9	7.2	7.6
20 For Persons btw 0-240% of Poverty d/	0.0	0.0	0.0	73.5	104.5	113.0	124.5	133.6	145.8	155.6
Cost-Sharing Subsidies:										
21 For Medicare Beneficiaries below Poverty	0.0	0.0	0.0	10.6	17.5	18.7	20.0	21.3	22.3	23.6
22 For Certain Low Income Beneficiaries	0.0	0.0	0.0	13.5	22.3	24.1	26.0	27.9	29.8	31.6
Total - Subsidies	0.0	0.0	0.0	102.0	150.3	162.2	177.0	189.7	205.1	218.4
TOTAL MANDATORY OUTLAY CHANGES	**0.0**	**-0.1**	**-0.2**	**19.6**	**26.5**	**15.0**	**6.3**	**-12.3**	**-12.8**	**-28.0**
DISCRETIONARY OUTLAYS										
23 Administrative and Start-Up Costs	*	0.5	2.6	9.3	11.3	11.8	12.7	13.4	14.1	14.8
Total Administrative and Start-Up Costs	*	0.5	2.6	9.3	11.3	11.8	12.7	13.4	14.1	14.8
TOTAL OUTLAY CHANGES	**0.0**	**0.4**	**2.4**	**28.9**	**37.8**	**26.8**	**19.0**	**1.1**	**1.3**	**-13.2**
RECEIPTS										
24 Income and Payroll Tax Effects	0.0	-6.1	-8.1	-19.5	-25.5	-26.6	-26.4	-22.6	-21.6	-20.8
25 Net Medicare Part C Premium Payments from Non-enrolling Employers	0.0	0.0	0.0	24.0	34.2	31.3	23.8	5.4	0.0	0.0
26 Extend Medicare Cov of, & Extend Phase in HI Tax to All State & Local Govt Employees	0.0	0.0	0.3	0.7	1.0	1.3	1.4	1.3	1.2	1.2
27 Health Benefits may not be Provided under Cafeteria Plans	2.3	3.8	5.4	5.0	5.3	6.1	6.9	7.7	8.5	9.1
28 Modification of COBRA continuation care rules			---------- Negligible Revenue Effects ----------							
29 Limitation on Prepmt of Medical Expenses			---------- Negligible Revenue Effects ----------							
30 Trmt of Nonprofit Health Care Organizations			---------- Negligible Revenue Effects ----------							

H.R. 3600 - HEALTH SECURITY ACT AS AMENDED BY THE COMMITTEE ON WAYS AND MEANS - PRELIMINARY

CHAIRMAN'S MARK, JUNE 10, 1994

By fiscal year, in billions of dollars.

Estimated On-Budget Effects	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
31 Increase Rpt Penalties for Nonemployees	0 0	*	*	*	*	*	*	*	*	*
32 Tax Treatment of Accelerated Death Benefits under Life Insurance Contracts	*	*	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1
33 Post-retirement Med & Life Insurance Reserves			- - - - - - - - - - - - - - - Negligible Revenue Effects - - - - - - - - - - - - -							
34 Increase in Tax on Tobacco Products	0 7	2 7	5.1	7.6	7.1	9.5	8.5	8.1	8.0	7.8
35 2% Excise Tax on Pvt Health Ins Premiums through 1999 and 1% thereafter	0 0	2 7	4.0	4.4	4.7	3.2	2.6	2.7	2.9	3.1
36 Self-employed Health Ins Deduction	-0 5	-0.4	-0.5	-1.3	-2.7	-2.9	-3.2	-3.4	-3.7	-3.9
37 Small Business Credit	0 0	0.0	0.0	-3.7	-5.9	-6.5	-7.0	-7.6	-6.9	-4.6
TOTAL RECEIPT CHANGES	2 5	2 7	6.1	17.1	18.1	15.3	6.5	-8.5	-11.7	-8.2
DEFICIT - MANDATORY CHANGES	**-2.5**	**-2.8**	**-6.3**	**2.5**	**8.5**	**-0.3**	**-0.2**	**-3.8**	**-1.1**	**-19.8**
DEFICIT - TOTAL CHANGES	**-2.5**	**-2.3**	**-3.7**	**11.8**	**19.8**	**11.5**	**12.5**	**9.6**	**13.0**	**-5.0**

SOURCES: Congressional Budget Office, Joint Committee on Taxation

* Less than $50 million.

NOTES:

a/ The estimate assumes that the expenditure limits would be less than fully effective.

b/ Medicare spending in this section included in line 7.

c/ The estimate assumes that benefit outlays and premium receipts from the Medicare Part C program would balance, except for the start-up premium offset.

d/ The benefit package is assumed to be 7 percent less generous than the Administration's plan. The mental health benefit is assumed to be tightly managed.

e/ The estimate assumesthat the small business credit has no effect on the distribution of the size of firms.

CONGRESSIONAL BUDGET OFFICE
U.S. Congress
Washington, DC 20515

Robert D. Reischauer
Director

July 28, 1994

Honorable Daniel Patrick Moynihan
Chairman
Committee on Finance
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

At your request, the Congressional Budget Office and the Joint Committee on Taxation have prepared the enclosed preliminary analysis of the Health Security Act, as ordered reported by the Committee on Finance on July 2. If you have any questions about this analysis or would like further information, please call me, or have your staff contact Paul Van de Water (226-2800) or Linda Bilheimer (226-2673).

Sincerely,

Robert D. Reischauer

Enclosure

cc: Honorable Bob Packwood
Ranking Minority Member

A PRELIMINARY ANALYSIS OF THE HEALTH SECURITY ACT AS REPORTED BY THE SENATE COMMITTEE ON FINANCE

July 28, 1994

The Congress of the United States
Congressional Budget Office

INTRODUCTION

The Congressional Budget Office (CBO) and the Joint Committee on Taxation (JCT) have prepared this preliminary analysis of the Health Security Act, as ordered reported by the Senate Committee on Finance on July 2, 1994. The analysis is based on the description of the Chairman's mark of June 28, the errata sheet of June 29, the amendments adopted during the Committee's markup, and information provided by the Committee's staff. Although CBO and JCT have worked closely with the staff of the Committee, the estimate does not reflect detailed specifications for all provisions or final legislative language and must therefore be regarded as preliminary.

The first part of the analysis is a review of the financial impact of the proposal. The financial analysis includes estimates of the proposal's effects on the federal budget, the budgets of state and local governments, health insurance coverage, and national health expenditures. The analysis also includes a description of the major assumptions that CBO has made affecting the estimate.

The second part of the analysis comprises a brief assessment of considerations arising from the proposal's design that could affect its implementation. The issues examined in this discussion are similar to those considered in Chapters 4 and 5 of CBO's analyses of the Administration's health proposal and the Managed Competition Act.

FINANCIAL IMPACT OF THE PROPOSAL

The Health Security Act, as ordered reported by the Senate Committee on Finance, aims to increase health insurance coverage by reforming the market for health insurance and by subsidizing its purchase. In the Congressional Budget Office's estimation, the proposal would add about 20 million people to the insurance rolls, and the number of uninsured would drop to 8 percent of the population. Initially, the proposal would add to national health expenditures, but by 2004 national health expenditures would be slightly below the baseline. Over the period from 1995 to 2004, the proposal would slightly reduce the federal budget deficit, and it would ultimately reduce state and local government spending as well.

The estimated effects of the proposal are displayed in the four tables at the end of this document. Table 1 shows the effect on federal outlays, revenues, and the deficit. Table 2 shows the effects on the budgets of state and local governments. Tables 3 and 4 provide projections of health insurance coverage and national health expenditures, respectively.

Like the estimates of other proposals for comprehensive reform--such as the single-payer plan, the Administration's proposal, the Managed Competition Act, and the bill reported by the Committee on Ways and Means--CBO's estimates of

the effects of this proposal are unavoidably uncertain. Nonetheless, the estimates provide useful comparative information on the relative costs and savings of the different proposals. In estimating the Finance Committee's proposal, CBO and JCT have made the following major assumptions about its provisions.[1]

Health Insurance Benefits and Premiums

The Finance Committee's proposal would establish a standard package of health insurance benefits, whose actuarial value would be based on that of the Blue Cross/Blue Shield Standard Option under the Federal Employees Health Benefits program. The Congressional Research Service and CBO estimate that such a benefit package would initially be 3 percent less costly than the average benefit of privately insured people today and 8 percent less costly than the benefit package in the Administration's proposal.

The proposal adopts the four basic types of health insurance units included in the Administration's proposal--single adult, married couple, one-parent family, and two-parent family. In general, workers in firms with fewer than 100 employees (and their dependents) and people in families with no connection to the labor force would purchase health insurance in a community-rated market. Firms employing 100 or more workers would be experience-rated. The estimated average premiums in 1994 for the standard benefit package for the four types of policies are as follows:

	Community-Rated Pool	Experience-Rated Pool
Single Adult	$2,330	$2,065
Married Couple	$4,660	$4,130
One-Parent Family	$4,544	$4,027
Two-Parent Family	$6,175	$5,472

In addition, separate policies would be available for children eligible for subsidies, as explained below. Supplementary insurance would be available to cover cost-sharing amounts and services not included in the standard benefit package.

---

1. For descriptions of CBO's estimating methodology, see Congressional Budget Office, *An Analysis of the Administration's Health Proposal* (February 1994), and *An Analysis of the Managed Competition Act* (April 1994).

Subsidies

The proposal would establish a system of premium subsidies for low-income people to encourage the purchase of health insurance. Families with income below 100 percent of the poverty level would be eligible for full subsidies, and those with income between 100 percent and 200 percent of poverty would be eligible for partial subsidies. The partial subsidies would be phased in between 1997 and 2000 by gradually increasing the income eligibility level. In addition, children and pregnant women with income up to 240 percent of the poverty level would be eligible for special subsidies.

In determining eligibility for premium subsidies, a family's income would be compared with the federal poverty threshold for that family's size, except that the threshold would be the same for families with four or more members. The estimate assumes that this limitation would apply for computing both regular subsidies and the special subsidies for children and pregnant women.

The maximum amount of the subsidy would be based on family income relative to the poverty level and on the weighted average premium for community-rated health plans in the area. The estimate assumes that a family's subsidy could not exceed the amount it paid for coverage in a qualified health plan. Therefore, if an employer paid a portion of the premium, the subsidy could at most equal the family's portion of the premium. The estimate also assumes that, except in 1997, the same formula would be used in each year to compute the amount of the subsidy, but that during the phase-in period no subsidies would be available to people above the applicable eligibility level.

Families would not be eligible, the estimate assumes, for both regular premium subsidies and special subsidies for children and pregnant women, but they could choose to receive the larger one. Families could use the special subsidies to help purchase coverage for the entire family, or they could purchase coverage only for the eligible children and pregnant women.

Families, children, and pregnant women with income below the poverty threshold would also be eligible for reduced cost sharing, as determined by the National Health Benefits Board. The estimate assumes that the board would require nominal cost-sharing payments. Health insurance plans would be required to absorb the cost of this reduced cost sharing. In addition, states would have the option of providing subsidies for cost sharing for people with income between 100 percent and 200 percent of the poverty level. The federal government would pay up to $2 billion a year to assist the states in providing these optional cost-sharing subsidies, and states would have to pay the rest of the cost.

The system of subsidies would be administered by the states. States would have the option of providing subsidies to eligible people beginning in 1996 and would be required to provide subsidies starting in 1997. Because of the difficulties involved in setting up the necessary administrative apparatus, the estimate assumes that states would not begin paying subsidies until 1997.

Medicaid and Medicare

Medicaid beneficiaries not receiving Supplemental Security Income would be integrated into the general program of health care reform and would be eligible for federal subsidies in the same way as other low-income people. Medicaid would continue to provide these beneficiaries with a wraparound benefit covering certain health care services not included in the standard benefit package. States would be relieved of their portion of Medicaid costs for these beneficiaries but would be required to make maintenance-of-effort payments to the federal government. The estimate assumes that these maintenance-of-effort payments would equal the appropriate portion of the states' Medicaid spending in 1994, increased in subsequent years by the rate of growth of national health expenditures plus an adjustment factor. The adjustment factor would equal 1 percentage point through 1997 and would be gradually reduced to zero by 2002.

The proposal would gradually phase out federal Medicaid payments to disproportionate share hospitals (DSHs). The estimate assumes that DSH payments would be limited to 10 percent of medical assistance payments in 1997, 8 percent in 1998, 6 percent in 1999, and 4 percent in 2000. In 2001, DSH payments would be repealed and would be replaced by a program to make payments to vulnerable hospitals. That program would have an annual appropriation of $2.5 billion.

Among the proposed changes in Medicare is a revision in the method of reimbursing Medicare risk contractors. The estimate assumes that this provision is intended to even out reimbursement rates without adding to total costs.

Revenues

The Committee's amendment that added the special subsidies for children and pregnant women also provided that the cost of these subsides would be covered by proportional increases in all of the revenue-raising measures in the proposal, as needed to keep the proposal from adding to the deficit. The estimate includes additional revenues of $13.6 billion over the 1996-2001 period as a result of this provision.

Fail-Safe Mechanism

In the present estimates, the fail-safe mechanism would not be called into play. If necessary, however, the proposal would scale back eligibility for premium and cost-sharing assistance, reduce the new tax deductions, and increase the out-of-pocket limits in the standard benefit package to prevent the proposal from adding to the deficit over a period of years. The deficit would be allowed to increase in any one year, however, but by no more than the amount of any cumulative savings from previous years.

Unforeseen circumstances--such as a major recession, an acceleration in the growth of health care costs, or a more rapid increase in the number of Medicare or Medicaid beneficiaries--could create a shortfall in funding and trigger the fail-safe mechanism. Although the proposal would give the Administration some flexibility in offsetting any unfinanced health spending, the bulk of any savings would have to come from limiting eligibility for subsidies. As a result, application of the fail-safe mechanism could make previously eligible people ineligible for subsidies and would reduce the extent of health insurance coverage.

OTHER CONSIDERATIONS

Like other fundamental reform proposals, the plan reported by the Senate Committee on Finance would require many changes in the current system of health insurance. For the proposed system to function effectively, new data would have to be collected, new procedures and adjustment mechanisms developed, and new institutions and administrative capabilities created. In preparing the quantitative estimates presented in this assessment, the Congressional Budget Office has assumed not only that all those things could be done but also that they could be accomplished in the time frame laid out in the proposal.

In CBO's judgment, however, there exists a significant chance that the substantial changes required by this proposal--and by other systemic reform proposals--could not be achieved as assumed. The following discussion summarizes the major areas of possible difficulty as well as some other possible consequences of the proposal.

Risk Adjustment

The proposal, like most others, assumes that an effective system could be designed and implemented to adjust health plans' premiums for the actuarial risk of their enrollees. In fact, the feasibility of developing and successfully implementing such a mechanism in the foreseeable future is highly uncertain. Inadequate risk-

adjustment techniques would have adverse consequences for both the community-rated and the experience-rated health insurance markets.

The primary purpose of the risk-adjustment system in the community-rated market would be to redistribute premium payments among health plans, compensating them for differences in risk. Without effective risk adjustment, the profitability of health plans in those markets would be partly determined by the plans' skill in attracting relatively healthy people. Since high-cost plans would be subject to a premium tax under this proposal, an effective risk adjustment would also be important to ensure that health plans were not taxed because their enrollees presented a higher risk.

While there would be no risk-adjustment payments in the experience-rated market, each plan that was not self-insured would have to have a risk-adjustment factor in order to determine whether it was liable for the tax on high-cost plans. Developing such factors would be extraordinarily difficult because the agency responsible for doing that would have to collect and analyze significant amounts of information from the many health plans, some of which would be very small, that made up the experience-rated market.

States' Responsibilities

Virtually all proposals to restructure the health care system incorporate major additional administrative, monitoring, and oversight functions that some new or existing agencies or organizations would have to undertake. A key question with any proposal is whether the designated organizations would have the appropriate capabilities and resources to perform their roles. In the Senate Finance Committee's proposal, states would bear the brunt of many of the responsibilities for implementation, and it is uncertain whether--and, if so, how soon--some states would be ready to assume them.

The states' primary responsibilities under the proposal would fall into four broad areas:

- determining eligibility for the new subsidies and the continuing Medicaid program;
- administering the subsidy and Medicaid programs;
- establishing the infrastructure for the effective functioning of health care markets; and
- regulating and monitoring the health insurance industry.

Determining Eligibility for Subsidies and Medicaid. The task of establishing and monitoring eligibility for subsidies would be an enormous one for states, even without the complications resulting from the dual structure that would subsidize premiums using two sets of rules (discussed in more detail below). According to CBO's estimates, in the year 2000, about 30 million families and single individuals would be receiving subsidies for health insurance premiums at any time. The actual number of applications would be much greater than that because of changes in employment, family status, or geographic location during the year. In addition, because Medicaid would be required to provide wraparound benefits, states would have to continue to operate their Medicaid eligibility systems using income criteria for families with more than four members that were different from the criteria used by the premium subsidy program.

States would also bear the responsibility for the required end-of-year reconciliation process in which the income of a subsidized family was checked to ensure that the family received the appropriate premium subsidy. Reconciliation would be a major undertaking since, although federal income tax information could be used, many of the families receiving subsidies would not be tax filers. Moreover, the process would require extensive interstate cooperation in order to track people who moved from one state to another during the year.

Administering the Subsidy and Medicaid Programs. The states would have other major administrative responsibilities for the subsidy and Medicaid programs. In particular, they would make subsidy payments to health plans and engage in outreach efforts to encourage enrollment of the low-income population. Health plans would be required to have an open-enrollment period of 90 days during the first year and only 30 days in all subsequent years. Establishing effective outreach programs would therefore be essential to ensure that low-income people enrolled in health plans during the open-enrollment window.

The optional programs in which states could participate would also have major administrative components. States electing to subsidize cost sharing for people with income between 100 percent and 200 percent of the poverty level would be responsible for administering those subsidies. Similarly, states would have to administer the complex system of subsidies incorporated in the proposal if they chose to expand home- and community-based services for the disabled. States could also choose to enroll beneficiaries of the Supplemental Security Income program in health plans, in which case they would have to negotiate separate premiums.

Establishing the Infrastructure for the Effective Functioning of Health Care Markets. States would be required to designate the geographic boundaries for the community-rating areas as well as the service areas for implementing the provisions regarding essential community providers. The liability for the tax on

high-cost community-rated and experience-rated plans would be calculated separately for each community-rating area. In addition, states would have to sponsor or establish purchasing cooperatives to serve those community-rating areas in which none were established voluntarily.

States would also have ongoing responsibilities for ensuring that health care markets functioned effectively. Those responsibilities would include establishing the system for adjusting premiums for risk, operating reinsurance pools until the risk-adjustment system was operating effectively, and redistributing losses resulting from the requirement that plans absorb the cost-sharing expenses for people with income below the poverty threshold.

Providing consumers with the necessary information to make informed choices among health plans would be another function of the states. States would be required to produce annual, standardized information comparing the performance of health plans in each community-rating area; they would also distribute that information, educate and provide outreach to consumers, and respond to complaints from consumers. To do all that effectively would require that states establish extensive systems for reporting and analyzing data and qualitative information. They would also be responsible for ensuring that health plans met federal standards for data reporting.

Regulating and Monitoring the Health Insurance Industry. The responsibilities for certifying insured health plans, self-insured plans that operated in one state only, and insurance plans for long-term care would all fall on the states. So too would the task of enforcing the new health insurance standards. Consequently, the duties of state insurance departments would grow considerably. Not only would they be responsible for many more health plans than they oversee today, but the activities they would have to monitor would be much more extensive. States would be encouraged to use private accreditation organizations to assist them with these tasks.

States would, moreover, be required to act in the event that health plans did not meet federal standards. For example, they might have to operate failed or noncompliant health plans for a transitional period to ensure continued access for the plans' enrollees, develop corrective programs, or design other options.

States would have to develop and implement programs to recover payment from automobile insurers for medical services resulting from automobile accidents. These programs would be required to have electronic data bases and include mechanisms for resolving liability issues or disputes rapidly.

At present, state insurance departments vary widely in their capabilities. It seems doubtful, therefore, that all of them would be ready for such an expanded role by 1997.

The Dual System of Subsidies

The proposal includes two subsidy schedules--one for low-income families and the other for low-income children and pregnant women. The two subsidy schemes would have to be integrated because children and pregnant women are a part of families; but integrating them in a sensible and administrable fashion would be extremely difficult. As now structured, the dual system of subsidies would create a confusing array of options from which low-income families would have to choose, would greatly complicate state administration of the already burdensome processes for determining eligibility and reconciling subsidies at year-end, and could result in real or perceived inequities in the treatment of low-income families.

In making its estimates, CBO assumed that no family could participate in both subsidy schemes at the same time but that families could choose whichever scheme gave them the larger subsidy. Permitting families to participate in both programs concurrently--for example, by obtaining special subsidies for the children individually as well as regular subsidies for single or dual policies for the parents --could cause the estimated cost of the subsidies to be somewhat higher than that shown in Table 1.

Insurance Costs for Moderate-Sized Firms

As is the case under other proposals that limit participation in the community-rated market to small firms and nonworkers, some moderate-sized firms--those with 100 to 300 or 400 employees--might face relatively high costs for coverage under the Senate Finance Committee's proposal. Just as they do under the current system, such firms would have to either self-insure or offer coverage through the experience-rated market. Moreover, they would be required to provide their employees with a choice of three plans, including a fee-for-service plan. Thus, the enrollment in some of those plans could be extremely small, especially since some employees in families with two workers could obtain their coverage elsewhere.

Small enrollments would, in turn, result in high administrative costs. Furthermore, because the firm's premiums would be experience-rated, a single employee with a costly medical problem could raise the firm's premiums significantly. Some plans could end up with ever-increasing premiums and

shrinking enrollment as people who could obtain cheaper coverage through their spouse's employer left the plan, raising its premiums further. At a minimum, employees would no longer have a realistic choice of three plans, and in extreme cases, all three plans might be quite expensive. In principle, individuals with income below the poverty level enrolled in such plans would be fully subsidized, but in fact they might have to contribute to the costs of their coverage if the premiums for all three plans were above the average for the community-rated market, which determines the maximum possible subsidy.

Tax on High-Cost Health Plans

The proposed tax on high-cost health plans would be difficult to implement. It would, moreover, result in different effective tax rates on excess premiums of the health plans offered by different insurers or sponsors. These differences might be viewed as arbitrary because they would vary significantly within and among community-rating areas.

The tax would be imposed at a 25 percent rate on the amount by which high-cost premiums exceeded a target premium set for each community-rating area. Various adjustments would be made to premiums to determine which plans would be classified as having high costs. Those adjustments would be difficult to make. Moreover, some of the necessary adjustments--such as those for differences in risk and the cost of living among geographic areas--would require data and methodologies that do not now exist.

The effective tax rate on excess premiums would generally be much higher than the statutory rate of 25 percent for two reasons. First, unlike most other excise taxes, this one would not be a deductible expense for health plans and self-insured employers; in effect, the tax would be paid from after-tax, rather than before-tax, profits. Second, if insurers that expected to be subject to the tax increased their premiums to reflect the additional tax liability, both their excise tax and income tax liabilities would also rise. As a result, the effective tax rate on excess health insurance premiums would not be 25 percent but 62.5 percent for most plans offered by taxable insurers and 33 percent for nontaxable (nonprofit) insurers. Self-insured employers who reduced other compensation to offset their higher expenses for health benefits would face an effective tax rate of 38.5 percent if they were taxable corporations and 25 percent if they were nontaxable sponsors of a health plan.

Although the tax would provide incentives for insurers to offer lower-cost plans, how insurers would actually respond is unclear. Because the calculation of the tax would be based on the combined cost of standard and supplemental policies, insurers might, for example, try to discourage enrollees from purchasing

supplements by raising those premiums considerably. Alternatively, they might not offer supplemental policies at all. A more fundamental problem for insurers is that they would not know the target premium--and, hence, their potential tax liability--at the time they established their premiums because those targets would be announced 90 days after the end of each open-enrollment period. That uncertainty would tend to increase the margins between insurance premiums and expected payouts as insurers attempted to protect themselves from the possibility that their plan would be considered a high-cost plan and thus subject to the tax.

The tax might be considered inequitable for a variety of reasons. In some community-rating areas, a small number of health plans--perhaps two or three--might dominate the market. Using the criterion that high-cost plans covered 40 percent of the primary insured population in an area could necessitate highly arbitrary decisions in the face of such indivisibilities. (For example, the highest-priced plan might cover 20 percent of the primary insured population while the top two plans covered 60 percent.) In the experience-rated market--if accurate risk-adjustment factors cannot be developed--small plans with little ability to control their premiums might well be the ones subject to the tax. Finally, plans in some areas of the country with low payments to providers and parsimonious practice patterns might be subject to the tax even though they were far less costly (even after the required adjustments) than nontaxed plans in other areas. This result could occur in spite of the fact that plans with adjusted premiums in the lowest quartile nationwide would not be subject to the tax.

Reallocation of Workers Among Firms

The proposal would encourage a reallocation of workers among firms and, in doing so, would increase its budgetary cost. This sorting would occur because the subsidies could be reduced by up to the amount that employers contributed for insurance; therefore, a worker employed by a firm that paid for health insurance would receive a smaller subsidy than a worker at a firm that did not pay. Some low-income workers could gain thousands of dollars in higher wages by moving to firms that did not contribute to employee health insurance, and a significant number of them would probably do so. That process would occur gradually as employment expanded in some firms and contracted in others. In the CBO estimate, this reallocation of low-wage workers among firms accounts for $12.6 billion of the cost of the subsidies in 2004.

In addition, some companies might stop paying for insurance, but the effect of that action on the government's costs would probably not be large, for several reasons. For one thing, the number of firms that would be likely to stop paying is limited because, if firms did so, high-wage workers in those firms would lose the tax benefits of excluding health insurance from the payroll tax. Moreover, the

net additional subsidy cost to the government from low-income workers in firms that dropped coverage would be largely offset by higher tax revenues from the workers because, without employer-paid coverage, wages would be higher.

Last, reducing subsidies by up to the amount that employers pay for insurance would mean that people with similar incomes and family circumstances would not be treated alike. In particular, workers at firms that paid for insurance would face larger costs for their insurance than similarly placed counterparts at firms that did not pay.

Work Disincentives

Like other reform plans with substantial subsidies, the Senate Finance Committee's proposal would discourage certain low-income people from working more hours or, in some cases, from working at all, because subsidies would be phased out as family income increased. For example, the subsidies for low-income families would be phased out as family income rose between 100 percent and 200 percent of the poverty threshold, and those for low-income children and pregnant women would be phased out between 185 percent and 240 percent of poverty. In both cases, many workers who earned more money within the phaseout range would have to pay more for their own or their children's health insurance, thereby cutting into the increase in their take-home wage. In essence, phasing out the subsidies would implicitly tax their income from work.

Estimating the precise magnitude of the implicit tax rates requires information that is not readily available, but rough calculations suggest that the rates could be substantial. In 2000, for example, the effective marginal levy on labor compensation could increase by as much as 30 to 45 percentage points for workers in families eligible for low-income subsidies and 20 to 40 percentage points for workers in families choosing the subsidies for pregnant women and low-income children. Moreover, those levies would be piled on top of the explicit and implicit marginal taxes that such workers already pay through the income tax, the payroll tax, the phaseout of the earned income tax credit, and the loss of eligibility for food stamps. In the end, some low-wage workers would keep as little as 10 cents of every additional dollar they earned.

If the employer did not pay for insurance, the implicit marginal rates from the phaseout of low-income subsidies would apply to workers whose income was within the broad range of 100 percent to 200 percent of the poverty level. But if the employer paid some of the costs for insurance, these marginal levies would apply to workers in a much smaller income range. Although this treatment of employer payments would reduce the size of the working population affected by higher marginal levies, it would create the previously described incentive for workers to move to firms that did not pay for insurance.

TABLE 1. PRELIMINARY ESTIMATES OF THE FEDERAL BUDGETARY EFFECTS OF THE HEALTH SECURITY ACT AS REPORTED BY THE COMMITTEE ON FINANCE

(By fiscal year, in billions of dollars)

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
MANDATORY OUTLAYS										
Medicaid										
1 Discontinued Coverage of Acute Care	0	0	-24.6	-36.7	-41.0	-45.8	-51.2	-56.9	-63.1	-69.7
2 State Maintenance-of-Effort Payments	0	0	-16.8	-24.0	-26.2	-28.4	-30.8	-33.4	-36.2	-39.2
3 Disproportionate Share Hospital Payments	0	0	-4.1	-7.0	-9.5	-11.6	-18.8	-20.7	-22.9	-25.2
4 Long Term Care Program/Change Fed Match	2.5	2.8	3.1	3.5	3.9	4.4	4.9	5.5	6.1	6.9
5 Administrative Savings	0	0	-0.3	-0.5	-0.5	-0.6	-0.7	-0.8	-0.8	-0.9
Total, Medicaid	2.5	2.8	-42.7	-64.7	-73.3	-82.0	-96.6	-106.3	-116.9	-128.0
Medicare										
6 Part A Reductions										
PPS Updates	0	0	-0.8	-2.3	-4.2	-6.4	-7.1	-8.1	-8.9	-9.8
Capital Reduction	0	-0.7	-0.8	-0.8	-0.9	-1.0	-1.2	-1.3	-1.4	-1.6
Disproportionate Share Hospital Reductions	0	0	0	-0.9	-1.2	-1.3	-1.4	-1.5	-1.7	-1.9
PPS-Excluded Payment Changes	0.1	0.1	0.2	0.2	0.2	0.2	0.2	0.3	0.3	0.3
Skilled Nursing Facility Limits	0	-0.1	-0.1	-0.2	-0.2	-0.2	-0.2	-0.2	-0.3	-0.3
Sole Community Hospitals	*	*	*	*	*	*	*	*	*	*
Medicare Dependent Hospitals	*	0.1	0.1	0.1	*	*	0.0	0.0	0.0	0.0
Long Term Care Hospitals	*	*	-0.1	-0.1	-0.1	-0.2	-0.2	-0.3	-0.3	-0.4
7 Essential Access Community Hospitals										
MAF Payments	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
Rural Primary Care Hospitals (RPCH) Pmts	0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.2	0.2	0.2
8 Part B Reductions										
Updates for Physician Services	-0.4	-0.6	-0.6	-0.7	-0.8	-0.8	-0.9	-1.0	-1.0	-1.1
Real GDP for Volume and Intensity	0	0	-0.3	-0.8	-1.8	-2.5	-3.3	-4.2	-5.3	-6.6
High Cost Hospitals	0	0	0	-0.5	-0.8	-0.8	-0.8	-0.9	-1.0	-1.0
Elim Formula Driven Overpayments	-0.5	-1.0	-1.3	-1.8	-2.3	-3.2	-4.2	-5.5	-7.1	-9.1
Eye & Eye/Ear Specialty Hospitals	*	*	*	0	0	0	0	0	0	0
Laboratory Coinsurance	-0.7	-1.1	-1.3	-1.4	-1.6	-1.8	-2.0	-2.3	-2.6	-2.9
Competitive Bid for Part B	*	-0.1	-0.1	-0.1	-0.1	-0.2	-0.2	-0.2	-0.2	-0.2
Competitive Bid for Clinical Lab Services	*	-0.2	-0.3	-0.3	-0.3	-0.4	-0.4	-0.5	-0.5	-0.6
Nurse Pract/Phys Assistant Direct Payment	0	0	0.1	0.2	0.2	0.3	0.3	0.4	0.5	0.6
Permanent Extension of 25% Part B Premium	0	0.5	0.9	1.4	0.8	-0.8	-2.8	-5.2	-8.2	-10.6
9 Parts A and B Reductions										
Medicare Secondary Payer	0	0	0	0	-1.2	-1.6	-1.9	-2.0	-2.2	-2.3
Expand Centers of Excellence	0	-0.1	-0.1	-0.1	-0.1	-0.1	*	*	0	0
Home Health Limits	0	0	-0.3	-0.6	-0.7	-0.7	-0.8	-0.9	-1.0	-1.0
Risk Contracts	*	0.1	0.2	0.2	0.3	0.3	0.4	0.4	0.5	0.6
Total, Medicare	0.1	-2.1	-2.9	-4.6	-6.2	-7.0	-15.3	-22.8	-30.0	-37.6

Continued

TABLE 1. Continued

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Other Health Programs										
10 Vulnerable Hospital Payments	0	0	0	0	0	0	2.5	2.5	2.5	2.5
11 Home and Community Based Care Program	0	0	0.3	0.7	1.0	1.4	1.6	1.7	1.9	2.0
12 Academic Health Centers Trust Fund	0	4.7	7.0	8.0	9.1	10.3	11.3	12.3	13.3	14.3
13 Grad Medical & Nursing Education Trust Fund	0	2.7	4.0	5.8	6.9	7.6	8.2	8.9	9.8	10.4
14 Medicare Transfer - Graduate Medical Education	0	-1.6	-2.2	-2.4	-2.5	-2.6	-2.8	-2.9	-3.1	-3.3
15 Medicare Transfer - Indirect Medical Education	0	-4.2	-4.5	-4.9	-5.4	-5.9	-6.5	-7.2	-7.9	-8.7
Total, Other Health Programs	0	0.6	4.6	7.2	9.1	10.8	14.3	15.2	16.5	17.2
Designated Urban/ Rural Health Care Access										
16 Investment in Infrastructure Development (Loans	0.3	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.5
Total, Urban/Rural Access	0.3	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.5
Subsidies										
Premium Subsidies:										
17 Persons between 0-200% of Poverty	0	0	52.4	86.2	97.6	109.3	121.0	133.6	147.3	161.2
18 Pregnant Women and Kids 0-240% of Poverty	---------- Included in Line 17 ----------									
Cost-Sharing Subsidies:										
19 Persons between 0-200% of Poverty b/	0	0	1.3	2.0	2.0	2.0	2.0	2.0	2.0	2.0
Total, Subsidies	0	0	53.7	88.2	99.6	111.3	123.0	135.6	149.3	163.2
Administrative Expenses										
20 Mandatory Administrative Expenses c/	0	0	2.4	4.0	4.3	4.7	4.8	4.9	4.9	5.0
MANDATORY OUTLAY CHANGES	1.4	1.8	13.9	26.5	25.5	24.2	19.6	17.2	14.0	10.4
DISCRETIONARY OUTLAYS:										
Administrative Expenses										
21 Administrative and Start-Up Costs	0.5	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.1
Studies, Research, & Demonstrations										
22 Network and Plan Development Grant Program	0.1	0.2	0.3	0.3	0.3	0.2	0.2	0.2	0.2	0.3
23 Operating Asst - Telemedicine Demonstrations	0.1	0.3	0.4	0.4	0.4	0.4	0.4	0.5	0.5	0.5

Continued

TABLE 1. Continued

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
24 Capital Investment - Grants	0.1	0.3	0.3	0.4	0.4	0.4	0.4	0.4	0.4	0.4
25 Biomedical & Behavioral Research Trust Fund	0	0.7	1.2	1.4	1.5	1.6	1.7	1.9	2.1	2.2
26 EACH/RAF/Rural Transition Demonstrations	a	0.1	0.1	0.1	a	a	a	a	a	a
Total Studies, Research & Demonstrations	0.1	1.1	1.6	1.9	2.0	2.0	2.1	2.3	2.5	2.6
DISCRETIONARY OUTLAY CHANGES	0.9	2.6	3.3	3.5	3.5	3.6	3.7	4.0	4.2	4.5
TOTAL OUTLAY CHANGES	2.3	4.4	17.1	30.0	29.0	27.7	23.3	21.2	18.2	14.9
RECEIPTS										
27 Increase in Tax on Tobacco Products	13.9	16.3	15.4	15.0	14.3	13.9	13.5	11.3	11.1	10.9
28 1.75% Excise Tax on Pvt Health Ins Premiums	0	3.5	6.2	7.2	7.8	8.5	9.2	10.0	10.9	11.8
29 Add Medicare Part B Premiums for High-Income Individuals	0	0	1.5	1.3	1.6	2.1	2.6	3.4	4.3	5.5
30 Increase Excise Tax on Hollow-Point Bullets	---------- Negligible Revenue Loss ----------									
31 Include Certain Svc-Reln Income in SECA and Excl Certain Invn-Reln Income from SECA										
a) General Fund Effect	0	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1
b) OASDI Effect	0	0.1	0.2	0.2	0.2	0.3	0.3	0.3	0.3	0.3
32 Extend Medicare Coverage & HI Tax to All State and Local Government Employees	0	1.6	1.6	1.5	1.5	1.4	1.4	1.3	1.2	1.2
33 Impose Excise Tax with Respect to Plans Failing to Satisfy Voluntary Contribution Rule	0	a	a	a	a	a	a	a	a	a
34 Repeal Flexible Spending Arrangements	0	0.3	0.5	0.7	1.1	1.3	1.4	1.4	1.4	1.5
35 Extend 25% Ded for Health Ins Costs of Self-Employed Individuals	-0.5	-0.3	0	0	0	0	0	0	0	0
36 Limit on Prepayment of Medical Premiums	---------- Negligible Revenue Gain ----------									
37 Deduct for Individuals Purchasing Own Health Ins	0	-1.4	-5.5	-8.1	-8.4	-8.7	-9.1	-9.8	-10.4	-11.0
38 Non-Profit Health Care Orgns/Taxable Orgns Providing Health Ins & Prepd Health Care Svs	---------- Negligible Revenue Effect ----------									
39 Trmt of Certain Ins Co with Regard to Sec 833	---------- Negligible Revenue Effect ----------									
40 Grant Tax Exempt Status to State Ins Risk Pools	a	a	0	0	0	0	0	0	0	0
41 Remove $150 million Bond Cap on Non-Hospital 501(c)(3) Bonds	a	a	a	-0.1	-0.1	-0.1	-0.1	-0.2	-0.2	-0.2
42 Clarify Tax Trmt of Long Term care Ins & Svcs	0	a	-0.2	-0.2	-0.2	-0.2	-0.3	-0.3	-0.3	-0.4
43 Tax Trmt of Accelerated Death Benefits Under Life Insurance Contracts	a	a	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1
44 Incr in Reporting Penalties for Nonemployees	0	a	a	a	a	a	a	a	a	a

Continued

TABLE 1. Continued

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
45 Post-Retirement Med & Life Ins Reserves			---------- Negligible Revenue Effect ----------							
46 Modify COBRA Continuation Care Rules			---------- Negligible Revenue Effect ----------							
47 Tax Credit for Practitioners in Underserved Area	a	-0.1	-0.2	-0.2	-0.2	-0.1	-0.1	a	a	a
48 Increase Expensing Limit for Certain Med Equip	a	a	a	a	a	a	a	a	a	a
49 Tax Credit for Cost of Personal Asst Svcs Required by Employed Individuals	0	a	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.2	-0.2
50 Disclosure of Return Info to State Agencies			---------- No Revenue Effect ----------							
51 Exempt Doctors from Section 457 Limits	a	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1
52 Impose Prem Tax with Respect to Certain High Cost Plans	0	a	0.9	1.4	1.6	1.7	1.9	1.8	1.9	2.0
53 Indirect Tax Effects of Changes in Tax Trmt of Employer & Household Health Ins Spending	0	a	1.2	1.4	1.4	1.4	1.4	1.6	1.6	1.5
TOTAL RECEIPT CHANGES	13.3	19.8	21.3	19.8	20.3	21.1	21.8	20.3	21.3	22.6
DEFICIT										
MANDATORY CHANGES	-11.9	-16.0	-7.4	6.7	5.2	3.1	-2.2	-3.1	-7.3	-12.2
TOTAL CHANGES	-11.0	-15.4	-4.2	10.2	8.7	6.8	1.5	0.9	-3.1	-7.7
CUMULATIVE DEFICIT EFFECT	-11.0	-26.4	-30.6	-20.3	-11.6	-5.0	-3.4	-2.5	-5.6	-13.3

SOURCES: Congressional Budget Office; Joint Committee on Taxation

NOTES:

The figures in this table include changes in authorizations of appropriations and in Social Security that would not be counted for pay-as-you-go scoring under the Budget Enforcement Act of 1990.

Provisions with no cost have been excluded from this table.

a. Less than $50 million.

b. The states would have the option to provide funding for cost-sharing subsidies for persons below 200% of poverty.

c. States would have substantial administrative responsibilities under this plan.

TABLE 2. PRELIMINARY ESTIMATES OF THE STATE AND LOCAL BUDGETARY EFFECTS OF THE HEALTH SECURITY ACT AS REPORTED BY THE COMMITTEE ON FINANCE

(By fiscal year, in billions of dollars)

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Medicaid										
1 Discontinued Coverage of Acute Care	0	0	-16.4	-27.5	-30.7	-34.3	-38.4	-42.7	-47.3	-52.3
2 State Maintenance-of-Effort Payments	0	0	16.8	24.0	26.2	28.4	30.8	33.4	36.2	39.2
3 Disproportionate Share and Vulnerable Hospital Payments a/	0	0	0.5	0.9	1.2	1.4	-0.2	0.0	0.3	0.6
4 Administrative Savings	0	0	-0.2	-0.4	-0.4	-0.5	-0.5	-0.6	-0.6	-0.7
Total - Medicaid	0	0	0.7	-3.0	-3.7	-5.0	-8.3	-9.9	-11.4	-13.2
Cost-Sharing Subsidies:										
5 Persons between 0-200% of Poverty b/	0	0	1.3	2.0	2.0	2.0	2.0	2.0	2.0	2.0
Total - Subsidies	0	0	1.3	2.0	2.0	2.0	2.0	2.0	2.0	2.0
Administrative Expenses										
6 Expenses Associated with Subsidies	0	0	0.8	1.2	1.3	1.5	1.5	1.5	1.5	1.6
7 General Admin and Start Up Costs	0	1.4	2.2	2.4	2.4	2.5	2.7	2.8	3.0	3.2
8 Automobile Insurance Coordination	0	0.3	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
Total - Administrative Expenses	0	1.7	3.0	3.7	3.9	4.1	4.3	4.5	4.7	4.9
Total State and Local Budgetary Impact	0	1.7	3.0	2.7	2.1	1.1	-2.0	-3.4	-4.7	-6.2

SOURCE: Congressional Budget Office.

a. The estimate assumes that states will continue to provide some assistance to hospitals serving disproportionately large numbers of uninsured or underinsured people.

b. The states would have the option to provide funding for cost-sharing subsidies for persons below 200% of poverty.

Table 3. Health Insurance Coverage
(By calendar year, in millions of people)

	1997	1998	1999	2000	2001	2002	2003	2004
				Baseline				
Insured	224	226	228	229	230	232	233	234
Uninsured	40	40	40	41	42	43	43	44
Total	264	266	268	270	272	274	276	278
Uninsured as Percentage of Total	15	15	15	15	15	16	16	16
	Health Security Act as Reported by the Committee on Finance							
Insured	241	244	246	249	251	253	255	257
Uninsured	23	22	22	21	21	21	21	21
Total	264	266	268	270	272	274	276	278
Increase in Insured	16	18	19	20	20	21	22	23
Uninsured as Percentage of Total	9	8	8	8	8	8	8	8

SOURCE: Congressional Budget Office.

Table 4. Projections of National Health Expenditures
(By calendar year, in billions of dollars)

	1997	1998	1999	2000	2001	2002	2003	2004
Baseline	1,263	1,372	1,468	1,613	1,748	1,894	2,052	2,220
Health Security Act as Reported by the Committee on Finance	1,297	1,403	1,515	1,636	1,761	1,903	2,056	2,218
Change from Baseline	34	32	27	21	13	9	3	-2

SOURCE: Congressional Budget Office.

CBO report
file

Copyright 1994 Globe Newspaper Company
The Boston Globe

February 9, 1994, Wednesday, City Edition

SECTION: NATIONAL/FOREIGN; Pg. 1

LENGTH: 1150 words

HEADLINE: Health plan dealt blow in report;
Congressional study sees rise in US deficit, employers' costs; Jill Zuckman of the Globe staff contributed to this report.

BYLINE: By Peter G. Gosselin, Globe Staff

DATELINE: WASHINGTON

BODY:

In a sharp critique of President Clinton's health care plan, the Congressional Budget Office said yesterday that the plan would drive up the federal deficit over the coming decade and raise employers' costs well beyond what the White House has estimated.

Moreover, the CBO said that by establishing health care as a right for allAmericans, the proposal would lock the government into providing such care, thus making the cost part of the federal budget - not a private-sector burden as the administration has contended.

The CBO's double-barreled conclusion flatly contradicted administrationefforts to portray its overhaul plan as largely a self-financed retooling of the nation's private health insurance system.

The report was immediately embraced by critics as evidence that the White House is trying to create a vast government bureaucracy and add to federal spending. The CBO concluded that the Clinton plan would boost the deficit $ 74 billion between now and the year 2000, not cut it $ 58 billion as the administration has asserted.

In issuing the somber critique, CBO Director Robert D. Reischauer coupled it with a plea for lawmakers to set aside political differences and pursue some kind of reform, even if not the president's.

"I have considerable foreboding," Reischauer told the House Ways and MeansCommittee, "that the information contained in my statement . . . might be used largely in destructive, rather than constructive ways." Committee members applauded when he finished.

But the politicking began almost instantly.

Clinton himself dismissed the CBO's conclusions as inconsequential.Traveling in Louisiana, the president said: "We'll fix that. That's not a problem. That's a Washington policy-wonk deal. No serious person out here in the real world will be too troubled by that."

Clinton supporters worked furiously to put the best face on the agency'sassessment. "CBO's analysis is a solid vote of confidence in the administration's plan," Sen. Edward M. Kennedy said.

Opponents showed equal fervor in their interpretation.

The Senate minority leader, Bob Dole of Kansas, said the CBO report"confirms what many of us have suspected for a long time: The Clinton plan calls for a multibillion-dollar dose of deficit spending and government control."

Rep. Newt Gingrich, the Republicans' No. 2 man in the House, said that withthe report's release the Clinton plan was "dead."

Indeed, the CBO report appeared to be just what White House health aideshave been desperate to avoid. It will allow critics to label as taxes costs that the administration had hoped would be seen as private health insurance premiums. And it will let opponents characterize the plan's elaborate collection of new agencies and boards as a single government bureaucracy.

The CBO acts as Congress' nonpartisan research arm, providing technical advice and fiscal opinions.

The report could hardly have come at a worse time for the administration.Last week, three major business groups, including the Business Roundtable, which represents chief executives of some of the nation's largest corporations, came out against the plan.

Despite its political consequences, the report was not all bad news for thepresident. Many of its most troubling findings were offset by information that appeared to confirm some of the administration's grandest claims for the proposal.

For example, the CBO concluded that the plan would raise the deficit $ 74billion by the year 2000, and $ 126 billion by 2003. But Reischauer said that those totals are only a small fraction of the amount the federal government is expected to overspend during that period. He added that by 2004 the plan would have no further negative effects on the deficit.

He also said the increase must be "balanced against the advantage of living in the nation where no one lacks health insurance coverage."

The CBO said costs for the new system would run about 15 percent higher than White House estimates and that both government and employer costs would be considerably steeper than had been thought.

According to the CBO, health coverage for a single person would cost $ 2,100if the plan were in operation today, not the $ 1,933 the administration estimated. Coverage for a couple with two children would cost $ 5,565, not the $ 4,361 the White House has said.

The CBO said that one of the most expensive items in the plan would begovernment subsidies for low-wage firms designed to help them pay their share of health coverage for their workers. By the year 2000, the bill for these subsidies would be $ 25 billion a year more than the White House has calculated, according to the agency.

But the CBO said the administration plan would eventually clamp down on thegrowth of national health care spending, which is now growing at several times the rate of inflation. The agency concluded that total spending on health would be $ 30 billion below what is currently expected by the year 2000, and $ 150 billion, or almost 7 percent, below what is expected by 2004.

The part of the CBO report that ultimately may prove most troubling has lessto do with costs than the relatively arcane issue of whether the administration would be required to include most spending for its plan in the federal budget.

Although nothing substantive about the plan would change whether it was on-or off-budget, both supporters and detractors of the measure believe that the political consequences would be tremendous because it would make the proposal appear to call for a government-run health system, and it would allow critics to label new spending for it as tax increases.

In his testimony, Reischauer carefully avoided the word "tax" and said theplan's costs should be treated as "governmental receipts." He suggested that the expenditures be distinguished from spending for regular government operations and treated in the same way as Social Security, which is given a separate accounting in the budget.

The CBO decision to call for the plan's costs to be included in thegovernment's financial books represents a victory for Republican critics of the measure, who lobbied hard for the inclusion, and appeared to represent a change of heart for the agency. CBO officials had suggested until recently that they would sidestep the question, saying it was up to Congress to decide.

The CBO report heartened advocates of competing plans on the right and theleft, who said its criticism of the White House proposal boosts chances that Congress will turn to their proposals.

"I'm happy with your decision," said Rep. Sam Gibbons, a Florida Democratwho backs a tax-financed "single payer" plan. Under questioning by Gibbons, Reischauer said that the Clinton plan and a single payer system would be equally effective in slowing the growth of national health spending.

Comparing the costs

GRAPHIC: CHART

LANGUAGE: ENGLISH

LOAD-DATE-MDC: February 11, 1994

Copyright 1994 The Washington Post
The Washington Post

February 9, 1994, Wednesday, Final Edition

SECTION: FIRST SECTION; PAGE A4

LENGTH: 793 words

HEADLINE: Clinton and the Analysts: A $ 133 Billion Difference of Opinion

SERIES: Occasional

BYLINE: Steven Pearlstein, David S. Broder, Washington Post Staff Writers

BODY:

President Clinton has put forward a credible plan for restructuring the nation's health system, but implementing it in the next few years will cost more than he thought and could overwhelm the frail institutions of government.

That was the carefully stated but unambiguous judgment delivered yesterday by the Congressional Budget Office, a nonpartisan policy analysis organization that enjoys unusual respect in Washington.

The CBO credited the administration with coming up with a framework that appears to reconcile what many had considered irreconcilable: extending health care to all Americans while at the same time slowing the growth of medical costs, which threaten to consume 20 percent of the nation's economic output by the end of the decade.

But the budget office implied what many of the country's leading business organizations said last week when, one after another, they declared that the Clinton plan was simply too much too fast.

The headline-grabbing news in the CBO report was that the Clinton plan would not reduce the budget deficit by $ 59 billion over the next five years, as the administration had estimated, but increase it by $ 74 billion. That $ 133 billion difference of opinion may have more political than economic significance: Both predict that the Clinton plan would begin saving money for the government, business and consumers by the year 2000.

But the administration has based its economic policy on lower deficits and lower interest rates, so the CBO report struck at a vulnerable point. Clinton has bragged that he was cutting the deficit by $ 500 billion in five years; at one blow, CBO wiped out more than one-quarter of those claimed savings.

Still, there were nuggets of good news for the administration in the CBO analysis.

The Clinton plan, it concluded, would not significantly slow the economy or result in the loss of jobs, as many critics have charged.

What few minimum wage jobs would be lost at restaurants and small manufacturing firms, it concluded, would likely be replaced in an expanded

health care sector. It predicted that the job market would improve because some working mothers and older workers would drop out of the work force, knowing that their medical costs would be covered.

The CBO also predicted that most employers would eventually enjoy lower health insurance premiums under the Clinton plan, passing on most of the $ 20 billion savings to their workers in the form of higher wages.

But there were also ominous warnings in the budget office's final chapter -- innocuously titled "Other Considerations" -- that the myriad old and new government agencies required to implement the plan may not be up to the task.

The proposed National Health Board, it warned, would need "a large, skilled professional staff" to perform "many difficult tasks . . . on extremely tight schedules." Ditto for the proposed regional health alliances, which are required by the plan to "combine the functions of purchasing agents, contract negotiators, welfare agencies, financial intermediaries, collectors of premiums, developers and managers of information systems and coordinators of the flow of information and money between themselves and other alliances."

"Any one of these functions could be a major undertaking for an existing agency with some experience, let alone for a new agency that would have to perform them all," CBO said.

The congressional analysts also said that they -- like many others who have pondered the subject -- were of two minds on the wisdom of the standby price controls of the Clinton plan.

On the one hand, they conceded that the premium caps might plausibly squeeze some waste and inefficiency out of the system. On the other hand, they might have the unintended consequences of reducing payments to doctors and hospitals, denying some medical services to some consumers, and creating a political brouhaha.

The only solace, they concluded, is that any other method of restraining health care spending would "likely generate similar stresses."

Much has been made of the CBO's judgment that the Clinton health plan so

intimately involves government in the nation's health system that the cost of the entire thing ought to be included in the government's set of accounts.

Critics argue that it only proves their point that the Clinton plan is just another big-government, bureaucratic nightmare.

But the CBO was making a more subtle point: Putting health care expenditures on the budget won't really make the plan more or less expensive. But only by exposing the true costs of health care to public scrutiny and political debate each year is there a chance of keeping the medical insurance guarantee from becoming another runaway entitlement program.

LANGUAGE: ENGLISH

LOAD-DATE-MDC: February 9, 1994

Copyright 1994 The New York Times Company
The New York Times

February 9, 1994, Wednesday, Late Edition - Final

SECTION: Section A; Page 16; Column 2; National Desk

LENGTH: 940 words

HEADLINE: When a Technical Point for Some Is a Major Issue for Others

BYLINE: By ADAM CLYMER, Special to The New York Times

DATELINE: WASHINGTON, Feb. 8

BODY:

Four months ago, when the Clinton health plan was bright and shiny, the Administration would have been delighted with a report from the Congressional Budget Office that the plan would reduce health care costs and eventually cut the deficit, though not as soon as President Clinton thought.

They would have been ecstatic if Robert D. Reischauer, the budget office's director, had told the House Ways and Means Committee that he would credit the plan with "100 percent effectiveness."

Mr. Reischauer did all that today. But he also said that the plan should beconsidered a Federal expenditure, not private enterprise. And while Mr. Clinton foresaw deficit-cutting starting in 1999, Mr. Reischauer thought that would not happen until 2004 or so, which helps Republicans in their arguments against Mr. Clinton's budgetary policies generally.

So the plan's defenders rushed to minimize the budget office's criticisms as trivial "inside the Beltway" concerns.

That Was Then . . .

Last fall, the Administration would have been trumpeting the good news.Today it had to fight off the bad.

Then, the atmosphere was different. Hillary Rodham Clinton went from committee to committee, with nobody challenging her seriously, and even Republicans sought her limelight.

Today, the Clinton health plan is under unremitting attack in television advertisements, the business groups the Clintons courted have spurned their

advances and the plan seems becalmed.

Moreover, Mr. Reischauer's judgment plays into the hands of Republicans who have been attacking the plan as "big government." It gives them a credible piece of supporting argument.

'Not a Problem'

And though Mr. Reischauer did not specifically call the compulsory insurancepremiums that employers would pay for their employees a tax, that did not stop some Republicans from saying he had. Haley Barbour, chairman of the Republican National Committee, said Mr. Reischauer had confirmed that the plan had a "gigantic payroll tax."

So there had to be answers, from high levels, to the Republican hyperbole, like the claim by Representative Newt Gingrich of Georgia that the Congressional Budget Office report rendered the health plan "dead."

From Louisiana, when he was campaigning for his health plan, Mr. Clinton scoffed at the deficit differences, saying: "We'll fix that. That's not a problem. That's a Washington policy wonk deal."

And Senator George J. Mitchell of Maine, the majority leader, took on the question of how the costs of the program should be treated in the budget -- "on budget" or "off budget" in capital jargon -- with disdain even before Mr. Reischauer began testifying. "I don't think it means anything outside Washington," Mr. Mitchell said. "This is a technical scoring decision."

A Close Question

There is something to that argument. Congressional Budget Office scoringdecisions can be awfully abstruse, and Mr. Reischauer acknowledged that this was a close question. It is not as if the Clintons' intention to list the enterprise as "off budget" had meant that its costs would be secret, as suggested by Representative Bill Archer, the very conservative Texan who is the senior Republican on the Ways and Means Committee. Under any name, they would have been added, or subtracted, from the deficit.

But the dismissal of the issue verges on the disingenuous from an Administration that went through considerable contortions, in a hopeless effort to placate the insurance companies, to create the complicated insurance purchasing alliances in such a way that the spending could be counted as private, not government. They didn't consider it a trivial Beltway issue back then.

A Point of Attack

Moreover, the instant gloss from television news was sharply negative. ABCcalled the finding "an embarrassment at a time when confidence in President Clinton is eroding."

What next?

If any was needed, the Reischauer report gives an impetus to finding ways to change the bill to attract more support. The regional alliances have always been one of the obvious points of attack, and various representatives questioning Mr. Reischauer got him to agree that if their role was changed, he might revise his judgment.

The deficit numbers are an issue. Mr. Clinton saw the deficit going down by 1999, and a total saving by 2000 of about $59 billion. The Congressional Budget Office calculated that deficits would increase by $74 billion between 1995 and 2000. But it figured that by 2004 the plan would start saving the Government

money.

Differences Not Vast

But Mr. Reischauer characterized those differences as "small," and he saidit would not take vast changes in the program to make it add up the way the Clintons claimed.

More significantly, Senator Daniel Patrick Moynihan of New York, a restrained supporter of Mr. Clinton but hardly a cheerleader, said the difference was "not a vast sum." Mr. Moynihan, who heads the Senate Finance Committee, said he thought the budget office report showed there was room for agreement.

And Leon E. Panetta, Director of the Office of Management and Budget, conceded that the determination that the health plan should be "on budget" was a setback. But he also said: "There were some pluses here. I mean the fact that C.B.O. acknowledges that we could guarantee all Americans health care, and that we will in fact lower health care expenditures in the long run, and that it's going to ultimately lead to deficit reduction."

But then Mr. Panetta added, "I sure as hell hope that this kind of in-the-Beltway scorekeeping issue is not used as a weapon to kill health care reform."

LANGUAGE: ENGLISH

LOAD-DATE-MDC: February 9, 1994

Copyright 1994 The San Diego Union-Tribune
The San Diego Union-Tribune

February 9, 1994, Wednesday

SECTION: NEWS; Ed. 1,2,3,4,5,6,7; Pg. A-1

LENGTH: 941 words

HEADLINE: Budget Office sees six years of red ink in Clinton's health plan

BYLINE: GEORGE E. CONDON Jr. and AMY BAYER
Copley News Service

BODY:

Congressional economists yesterday said President Clinton's health reform plan would initially increase the deficit, but eventually slow the growth of health care costs.

In the long-awaited report, the nonpartisan Congressional Budget Office (CBO) agreed with most of Clinton's economic assumptions, including his assertion that the reform plan ultimately would trim federal spending.

Over the next six years, however, the CBO said Clinton's plan would add $74 billion in federal red ink rather than cut $58 billion as the White House contends.

That finding poses problems for the White House on Capitol Hill, where lawmakers could force the president to propose new taxes or spending cuts to make up the difference.

The report also gives new ammunition to Clinton's critics in its recommendation that health insurance premiums paid to health alliances be considered part of the federal budget, rather than an off-budget item as the White House prefers.

Clinton, anticipating the report, launched a vigorous defense of his health care plan in a speech earlier in Shreveport, La.

He made no mention of the CBO report, but he was asked about it by reporters, and dismissed it as a "Washington policy-wonk deal."

"We'll fix that," Clinton said. "No serious person out here in the real world will be too troubled by it."

The CBO report, released during a hearing of the House Ways and Means Committee, notes that the magnitude of Clinton's plan makes it "extremely difficult"

to predict its impact.

But the report made several broad predictions about health care under Clinton's plan. Among them:

Health care spending initially will rise as people not now insured gaincoverage, but within six years, cost controls could bring spending in line with

inflation.

Some businesses and industries will pay more, but overall, U.S. businesscosts for health insurance will be "significantly reduced."

Cash wages for most U.S. workers will rise if employers' health care costsfall.

The plan will lure some workers to retire early or otherwise leave the workforce because they no longer will risk losing health coverage. But universal health care could lure many welfare recipients into the job market.

Health care premiums for workers and employers will be about 15 percenthigher than the administration's estimate of about $5,000 a year for an average working family.

One White House aide said that opponents will label premiums "taxes" if they are included in the budget, giving health-care critics political firepower they otherwise might not have.

Indeed, soon after the report's release, the Republican National Committee cited the CBO as "confirmation" that Clinton wants to create "a government-run health care system, financed by a gigantic payroll tax."

In his testimony, CBO Director Robert Reischauer went out of his way to be conciliatory toward the administration, cautioning against "hit-and-run journalists and cheap-shot artists" who would use the report "in destructive rather than constructive ways" and try to give some of its points more weight than they deserve.

He stressed, too, that lawmakers have to keep the higher deficit estimate in perspective, as it accounts for only a tiny percentage of total U.S. health care spending.

Any deficit, Reischauer said, must be "weighed against the benefits of living in a nation in which no one lacks health insurance."

Opponents, however, found plenty of ammunition in the CBO report.

Texas Rep. Bill Archer, the ranking Republican on the Ways and Means Committee, said with some glee that the report is "going to ruin someone's day at the

other end of Pennsylvania Avenue." The CBO confirms many critics' fears, Archer said, that the plan is a "massive new entitlement" that will lead to runaway federal spending.

Rep. Pete Stark, D-Calif., a self-described "skeptic" of the Clinton plan, noted that the CBO report puts Clinton in a "budget fix."

"It looks like he's got to come up with some new money and, in this budget climate, that's going to be tough," Stark said.

Clinton, traveling in Louisiana, targeted his defense not at the numbers but at his critics, attacking the "propaganda" of the insurance companies, corporations and other special interests.

"We're moving the insurance companies out of the driver's seat," Clinton said, "and letting the people and the businesses have more influence."

Amid the skeletons of half-assembled trucks in a General Motors assembly plant, Clinton criticized alternative plans that promote "universal access" to coverage rather than his promised "universal coverage."

Pointing to a completed truck behind him, he said: "There's universal access' to this truck, but only people with the money" can buy it.

Clinton also denied critics' claims that he wants to have the government take over the health care system.

"It isn't true," he said, promising a system built around "private health insurance, private doctors, private providers."

It was Clinton's first speech on health care since he lost the support of three critical business groups -- the Business Roundtable, the U.S. Chamber of Commerce and the National Association of Manufacturers.

General Motors Chairman Jack Smith, who introduced Clinton via satellite from Detroit, stopped short of endorsing the Clinton plan. He did, however, allow the president's speech to be broadcast to GM workers in plants around the country.

The speech also gave Clinton a chance to mend fences with the United Autoworkers Union, which had fought him last year on the North American Free Trade Agreement.

LANGUAGE: ENGLISH

LOAD-DATE-MDC: February 10, 1994

Copyright 1994 The Chronicle Publishing Co.
The San Francisco Chronicle

FEBRUARY 9, 1994, WEDNESDAY, FINAL EDITION

SECTION: NEWS; Pg. A1

LENGTH: 1112 words

HEADLINE: New Setback For Clinton's Health Plan
Congressional report says spending should be part of budge

BYLINE: Carolyn Lochhead, Chronicle Washington Bureau

DATELINE: Washington

BODY:

Striking a body blow to President Clinton's health care proposal, thenonpartisan Congressional Budget Office yesterday called it a new universal entitlement program whose spending and taxes should be registered in the federal budget.

The report also said the plan could add $ 74 billion to the federal deficit over five years, rather than reduce it by $ 59 billion as the White House has claimed.

The president had been insisting, with increasing emphasis in recent weeks, that his proposal builds on the private sector, offering "guaranteed private insurance" to all Americans. The White House had been lobbying furiously to convince the Congressional Budget Office that the plan's mandatory employer- and worker-paid premiums are not taxes and that its costs are not part of the federal budget.

The long-awaited report by the office's director, Robert Reischauer, released before the House Ways and Means Committee, contradicts that assessment, a verdict that throws considerable doubt on the political viability of the Clinton proposal.

The report said the administration's bill would "establish both a federal entitlement to health benefits and a system of mandatory payments to finance those benefits that represents an exercise of sovereign power." The regional health purchasing alliances that the plan envisions would "operate primarily as agents of the federal government," the budget office said. "The universality of the entitlement, the mandatory nature of the premiums and the major financial participation of the U.S. Treasury outweigh other considerations."

Clinton, after a speech to workers at a General Motors truck plant in Shreveport, La., was quick to dismiss the report as "not a problem."

"We'll fix that," Clinton said. "That's a Washington policy wonk deal. No serious person out here in the real world will be too troubled by that."

The Congressional Budget Office did have some good news for the administration, saying that by the year 2004, the nation would spend 7 percent less on health care under the plan than if the current system remained in effect, a savings of $ 150 billion that year and growing thereafter.

Reischauer also went out of his way to call the differences in financial estimates "relatively small potatoes in the great scheme of things."

But the report clearly damages the president, given the importance that the White House has given to its health care proposal. The plan is at the forefront of Clinton's legislative agenda, and the White House has staked its fortunes on its passage in some form.

The Congressional Budget Office serves as Congress' arbiter on fiscal matters. Given its nonpartisan makeup and its reliability, the White House would be hard put to call its findings into question.

"The White House was merciless in the pressure they put on Bob Reischauer to get him to change his testimony," said Representative Fortney (Pete) Stark, the Hayward Democrat who chairs the House Ways and Means health subcommittee. "You would think Somalia had invaded us, the way they were running around here."

As expected, Republicans were jubilant.

'It's going to ruin someone's day . . . but on the other end of Pennsylvania Avenue rather than on Main Street," said the ranking health subcommittee Republican, Representative Bill Archer of Texas. The report, he said, revealed the Clinton plan as "a massive new entitlement program" that risks "the quality and availability of American medical care."

LARGER THAN SOCIAL SECURITY

A hugely ambitious undertaking, the Clinton plan would rival in magnitude the creation of Social Security during the 1930s under President Franklin Roosevelt. In fact, the Congressional Budget Office report projected that the plan would cost $ 513 billion by the year 2004, about one-quarter more than Social Security, currently the government's costliest program, which will cost a projected $ 412 billion that year.

The report also said premiums would cost 15 percent more than the administration says.

Reischauer played down the increase in the deficit that the plan might cause and the discrepancy with administration deficit figures, saying the $ 74 billion addition to

the deficit would account for less than 3 percent of projected federal spending on Medicare and Medicaid over the period.

The budget office accepted the administration's assumptions that price controls on insurance premiums would hold down costs. But it warned that the spending slowdown could entail sacrifices. Although some of the savings might come from eliminating the ample "fat" in today's system, the report said, cost reductions could cause medical care rationing, including "longer waiting times" for nonemergency care, "reduced access to new high-cost medical technologies" and a slowdown in medical research and medical technology improvements.

Reischauer stressed the uncertainty surrounding the cost estimates in light of the scope of the plan, which attempts to remake one-seventh of the U.S. economy. The "entire marketplace and the configurations of the actors in it would be changing," the report said, "and there is no precedent for estimating the effects on health spending or the economy."

Stark, who favors a Canadian- style system in which the government pays for all medical bills, said the White House had been "trying to pretend (that its plan) entailed no federal involvement, wouldn't cost anybody anything and that the entitlement caps wouldn't be reached. And we knew that wasn't true."

STANDARD OF MEASUREMENT

Although the CBO report concentrated on the administration's proposal, it also establishes a benchmark from which to gauge the effect of the raft of competing proposals on Capitol Hill.

The budget office probably will view any health care mandate as a tax, including the Republican proposal to require individuals to purchase health insurance, sponsored by Senator John Chaffee of Rhode Island.

In an unusual epilogue to his testimony, Reischauer said he delivered the report with "considerable foreboding" that it would be "used in destructive rather than constructive ways," becoming a weapon in the "semantic mud- wrestling" surrounding the health care debate.

Reischauer, a Democrat, urged members to recall Congress' historic role in the creation of Medicare in the 1960s, the big, and popular, government health care program for the elderly. He said President Clinton deserves credit and thanks for tackling a policy morass that had eluded similar attempts by presidents from Richard Nixon to Jimmy Carter.

LANGUAGE: ENGLISH

Copyright 1994 The Times Mirror Company
Los Angeles Times

February 9, 1994, Wednesday, Home Edition

SECTION: Part A; Page 1; Column 2; National Desk

LENGTH: 1233 words

HEADLINE: BUDGET OFFICE SEES HEALTH PLAN WIDENING DEFICIT

BYLINE: By JAMES RISEN, TIMES STAFF WRITER

DATELINE: WASHINGTON

BODY:

In a major setback for the Clinton Administration's health care initiative, the Congressional Budget Office said Tuesday that the reform plan would create a massive new government program that ultimately would prove more costly than Social Security and would widen the federal deficit by $74 billion during its first six years.

In its long-awaited report, the nonpartisan budget agency said the mandatory insurance premiums that employers would be required to pay under the Clinton plan should be considered government "receipts" and included in the federal budget.

Characterizing the payments as receipts is a less politically charged definition than using the term "tax," but the budget office suggested that the mandatory premiums would have essentially the same effect as new payroll taxes on American workers.

Under the Clinton plan -- which the President has asked Congress to approve this year -- most employers would be required to pay at least 80% of the cost of providing insurance for their workers, with employees picking up the remainder. The government would subsidize premium costs for some small businesses and low-income workers.

The CBO, which provides official budgetary rulings for Congress, said that the Clinton health plan should be regarded as a huge new federal entitlement program. The premium payments and government subsidies would rise to an estimated $513 billion annually by the year 2004, nearly 20% more than projected Social Security outlays in that year, the agency said.

Dealing another blow to the Administration's reform campaign, which has sought to portray the President's initiative as a private-sector solution to the health crisis, the CBO said that the network of health alliances it would establish should be considered

government entities.

As envisioned by the Administration, the alliances would act as insurance buying cooperatives for consumers and employers. The quasi-public entities would collect the mandatory premiums from employers and their workers, and then use the funds to buy insurance from a handful of large private insurers on their behalf.

The CBO report is politically damaging because it directly challenges many of the basic assumptions on which the White House health care plan is founded. The Administration has argued that its "managed competition" plan represents a sophisticated public-private partnership designed to harness the power of the marketplace to extend coverage to all Americans, while reining in runaway health care costs.

Administration officials have taken pains to design the plan so that it would not be characterized as a significant expansion of the federal government's role in an industry that accounts for 14% of the nation's economy.

By defining the proposed system as a new entitlement in the tradition of Social Security and Medicare, the CBO has made it much easier for opponents to portray the Clinton plan as a form of socialized medicine.

In rendering its bombshell ruling, the CBO resisted intense pressure from White House officials, including the President and First Lady Hillary Rodham Clinton. The Clintons argued that the insurance premiums, and most of the plan's costs and expenditures, should be left out of the federal budget.

By determining that the President's reform effort would create a new government program, the CBO report also will impose much tougher budgetary and cost discipline on the White House program.

CBO Director Robert D. Reischauer told the House Ways and Means Committee Tuesday that including the health plan in the federal budget would make it far more difficult for the government to use "accounting chicanery" to hide its true costs.

The CBO's verdict that the plan would increase the federal deficit is another blow to the Administration. The White House has stressed repeatedly that its health reform campaign offers the only path to deficit reduction, because it will restrain the exploding costs of the government's existing health care programs -- Medicare for the elderly and Medicaid for the poor. The Administration has estimated that its plan would reduce the deficit by $58 billion between the years 1995 and 2000.

But the CBO disagreed. Although the agency concurred that some form of health care reform is needed to curb the deficit, its report found that the Clinton plan would actually increase the shortfall by $74 billion for the remainder of this decade. The figure would increase to $126 billion by the year 2004. The budget office said that the

Clinton plan would not result in significant deficit reduction until well after the turn of the century.

In another troubling observation, the report agreed with private studies that say the Administration has underestimated by at least 15% the costs of providing health care to all Americans. While the White House has said that insurance premiums would cost about $4,200 a year for an average family of four under its proposal, the CBO projected a cost of $5,565 for an average two-parent family.

Testifying at a packed committee hearing, Reischauer said that the costs are understated largely because the White House failed to anticipate many of the consequences of providing universal coverage and subsidizing firms and workers who can't afford to pay the premiums.

The CBO estimated that the subsidies for employers would cost $58 billion annually by the year 2000, or $25 billion more than the Administration's forecasts. Reischauer said the CBO estimates reflect the agency's determination that the Clinton benefit package would be more generous than the average health care plan available to American workers today.

Reischauer stressed that his agency's report was not intended to be a condemnation of the Clinton plan. The CBO forecasts that by the year 2004, the Clinton reform measure would reduce overall national health care spending by 7%, and "holds out the promise of reducing the deficit" sometime after the year 2004, Reischauer said.

Clearly stung by the report, the White House and its Democratic allies in Congress immediately sought to downplay its significance.

The President, traveling in Shreveport, La., insisted it was a minor problem. Following the Administration line, Democrats on the House Ways and Means Committee stressed that the question of whether the Clinton health care system would be considered a government program is an "inside-the-Beltway issue."

Rep. Robert T. Matsui (D-Sacramento), a member of the panel, insisted that the report is "good news for the Administration" because it shows that, under the Clinton plan, both overall health care costs and the deficit would finally begin to decline by the year 2004.

But Ways and Means Chairman Dan Rostenkowski (D-Ill.) acknowledged the adverse political impact of the report. "I've always said that the Clinton plan would be modified," Rostenkowski said.

Clinton's critics agreed that the report could prove politically devastating. In effect, it strips away the distinctions the White House has sought to create between its managed competition concept and a more direct government intervention in the health care system.

"Today, CBO confirmed what many of us recognized months ago -- the Clinton health care reform plan requires substantial new taxes," said Sen. Pete V. Domenici (R-N. M.).

Times staff writers Karen Tumulty and David Lauter contributed to this story.

LANGUAGE: ENGLISH

LOAD-DATE-MDC: February 10, 1994

Copyright 1994 The New York Times Company
The New York Times

February 10, 1994, Thursday, Late Edition - Final

SECTION: Section D; Page 20; Column 1; National Desk

LENGTH: 945 words

HEADLINE: Clinton Health Plan: Testimony Reveals the Government's Hand

BYLINE: By ROBERT PEAR, Special to The New York Times

DATELINE: WASHINGTON, Feb. 9

BODY:

Though President Clinton dismissed its conclusions as "a policy wonk deal," the Congressional Budget Office has put its finger on something the Administration was loath to acknowledge: Mr. Clinton's health plan depends heavily on the power of the Government to compel behavior that would not otherwise occur in the private market.

Such an exercise of Federal power may be good or bad, but it should be recognized for what it is, said Robert D. Reischauer, director of the budget office, who has testified before two Congressional committees this week.

In some ways, his statement underscored the obvious: the reason for any newgovernmental program is to produce results that would not otherwise occur. But in public remarks, the President has gone to great lengths to minimize the Government's role and to insist that his plan represents merely an expansion of the existing system of private health insurance, a more rational version of the market, not a vast new Federal enterprise.

Flexing 'Sovereign Power'

In testimony on Tuesday and again today, however, Mr. Reischauer said theClinton plan "would establish a universal entitlement to health insurance that would be largely financed by mandatory payments resulting from an exercise of sovereign power."

Under this plan, he said: "Federal law, rather than the employer, would determine the benefits and premiums. The transaction would no longer be voluntary. The employer could not drop or change the terms of the health insurance benefit."

Under the Clinton plan, most Americans would get coverage through insurance purchasing pools known as health alliances. The alliances "would operate primarily

as agents of the Federal Government," not as private entities, Mr. Reischauer said, adding that by the year 2004 the alliances would get 30 percent of their money from the Federal Government.

"The health alliances would be more like Federal agencies than like state or private entities," and their spending should be included in the accounts of the Federal Government, where they would be subject to "a full accounting and some

sort of control," Mr. Reischauer said.

Product of Policy Wonks

The President brushed aside the significance of these recommendations, justas he minimized the criticism of his health plan last week by the Business Roundtable, a group of executives from about 200 of the nation's largest corporations. Referring to Mr. Reischauer's concerns, Mr. Clinton said: "We'll fix that. That's not a problem. That's a Washington policy wonk deal."

But the Clinton plan was devised by a small army of policy wonks. And they had just such concerns in mind -- as something to avoid. One such White House expert said today, "The concern that the alliances would be viewed as governmental agencies, collecting taxes, heavily influenced the design of our plan."

Under the President's proposal, premium payments would flow from consumers and employers to alliances, then to doctors and hospitals, without going through the Federal Treasury.

A major reason for the complexity of Mr. Clinton's plan, with its premiums and subsidies, is that he was determined to avoid a payroll tax. Administration officials acknowledge that such a tax might have been simpler to administer, but they say it would have been politically unacceptable.

Mr. Reischauer said the premium payments should be treated as Government receipts. This conclusion reduces the political advantage that Mr. Clinton thought his plan had over the "single payer" bills sponsored by two Democrats in Congress, Representative Jim McDermott of Washington and Senator Paul Wellstone of Minnesota, who explicitly propose new taxes to finance universal health care.

The Congressional Budget Office also said Mr. Clinton's health plan would increase the Federal budget deficit over the next decade, rather than reducing it as the President had predicted. And Mr. Reischauer said the premiums would have to be 15 percent higher than the White House estimated.

These were differences of degree -- Mr. Clinton had acknowledged an initial rise in the deficit -- and Mr. Reischauer called the disparities "small potatoes" in a world of trillion-dollar Federal budgets.

Some Findings Welcomed

After consulting with the President today, Democratic Congressional leadersechoed the President's statement that the discrepancies were not very significant. Richard A. Gephardt, the House majority leader, said the budget office report was "not a problem." And House Speaker Thomas S. Foley of Washington said that modest changes in Mr. Clinton's plans would remedy the problems identified by the Congressional Budget Office.

Supporters of the Clinton plan welcomed some of Mr. Reischauer's findings, particularly his conclusion that the plan would increase the range of health care choices "for the vast majority of Americans." In addition, Mr. Reischauer said the plan would slow the growth of health spending overall and probably reduce the total spent on health insurance by all businesses taken together.

But these predictions are based on Mr. Reischauer's assumption that the President's proposal to limit health insurance premiums would work as intended and would be completely effective.

Kathryn M. Langwell, director of health economics at the accounting firm KPMG Peat Marwick, said she was surprised at this assumption. Ms. Langwell, who supervised health research at the Congressional Budget Office from 1989 to 1993, said, "In previous cost estimates of health reform plans, the budget office did not assume that expenditure caps would be 100 percent effective, and I doubt whether they will be."

GRAPHIC: Photo: Robert D. Reischauer, director of the budget office, testifying yesterday in Washington at a hearing of the Senate Finance Committee. (Stephen Crowley/The New York Times)

LANGUAGE: ENGLISH

LOAD-DATE-MDC: February 10, 1994

Copyright 1994 The Times Mirror Company
Los Angeles Times

February 14, 1994, Monday, Home Edition

SECTION: Part A; Page 1; Column 3; National Desk

LENGTH: 1560 words

HEADLINE: HEALTH PROGRAM COULD REALIGN WORK FORCE; REFORM: BUDGET OFFICE WARNS THAT SKILLED-UNSKILLED GAP COULD WIDEN. SMALL FIRMS MIGHT KEEP WAGES LOW.

BYLINE: By JAMES RISEN, TIMES STAFF WRITER

DATELINE: WASHINGTON

BODY:

The issue has been overshadowed so far by the debate over government spending, but congressional analysts warn that President Clinton's health care reform plan could contribute to a fundamental restructuring of the U.S. work force.

According to a report by the Congressional Budget Office, the Clinton plan could widen the existing divide between professional and unskilled workers, accelerate the trend toward corporate "outsourcing" of work to independent contractors and create new incentives for small businesses to stay small and keep wages low.

The CBO analysis, while not intended as an attack on the Clinton plan, could provide new ammunition to congressional opponents who hope to stop the White House from rewriting the rules governing a sector that accounts for one-seventh of the nation's economy.

The nonpartisan budget agency, which prepares financial analyses at the request of Congress, says some of the labor market changes it foresees could work to the advantage of employees. And it notes that the existing system, which leaves 37 million Americans without health insurance and forces others to pay far more than their fair share, is hardly a model of fairness or efficiency. Still, the budget office's predictions about potential employment impact could increase the wariness of lawmakers who are already hesitant to endorse what is arguably the largest piece of social legislation in the nation's history.

"Any plan that is this complicated is going to have all sorts of unintended consequences," said Rudy Penner, an analyst at KPMG Peat Marwick, a Washington consulting firm. "We could sit for hours and only think of a fraction of them.

"It takes a lot of poring over the details to recognize all of the possible consequences, and I'm sure we missed a lot of them," said CBO Director Robert D. Reischauer. "If you make a big change like this, you suddenly get all kinds of consequences that you didn't think of."

Administration officials acknowledge that they recognized the potential for labor market disruptions long before Reischauer released the CBO analysis, which said the health plan should be regarded as a vast new government entitlement program and estimated that it would cause the federal deficit to balloon in the near term. But the Administration officials said they saw no reason to call attention to the employment impact.

"We were surprised no one picked up on this before CBO," said one senior Administration policy-maker who requested anonymity. "We didn't really hide it; we just didn't stick it in your face for you to see."

The potential work force changes identified by the CBO are largely attributable to the Administration's decision to soften the blow of health care reform on small-business proprietors, who are among the most vocal opponents of mandatory universal coverage.

Under the Clinton plan, all employers would be required to provide health insurance for their workers and to pick up most of the cost. Once the plan was fully phased in, no company would be required to spend more than 7.9% of its total payroll for health coverage.

But small firms with many low-wage employees would get a big break: Depending on their size and average wages, the maximum contribution would be reduced to as little as 3.5% of payroll. The government would pick up the difference.

The impact of the subsidies could be dramatic. The CBO estimates that a typical employer whose workers receive an average of $40,000 a year would be required to pay an unsubsidized premium of $2,031 for each single employee on its payroll. But a small firm employing unskilled workers whose wages average $10,000 a year would qualify for the maximum subsidy, lowering its cost per employee to only $350.

Under the Clinton plan, the less an employer paid its workers, the bigger the subsidy it would receive.

The CBO warns that the subsidies could contribute to the stratification of the U.S. work force by creating incentives for low-paid workers to migrate to small employers, and for well-paid, highly educated workers to congregate at bigger companies.

The potential impact on the labor market is enormous, the budget office said. By

1998, an estimated 8 million low-wage workers now working for larger employers would be worth considerably more to small firms that qualify for the health care subsidies.

The CBO predicts that 20%, or 1.6 million, of those workers would actually change jobs. Some would go voluntarily because subsidized firms could afford to pay them more. Some would be forced to make the move as the private sector restructured itself in response to the Clinton plan.

The potential shift would be so large that it could add $12 billion a year to the cost of the government subsidies starting in the year 2004, the CBO analysis said.

"Workers at different wage levels would have an incentive to work for different firms," it said, noting that the creation of two classes of employers -- a phenomenon it calls "labor sorting" -- would "reduce the efficiency of the labor market."

The long-term impact on the U.S. economy is far from certain.

"The reason this is a problem is that corporations might start doing things that don't make economic sense at all except to take advantage of these federal subsidies," said John Shiels, a health care expert with Lewin-VHI, a Fairfax, Va., consulting firm that has conducted its own analysis of the Clinton plan.

"Corporations might begin to organize themselves in ways they otherwise wouldn't, and become less efficient as a result," Shiels said. "Those inefficiencies should be counted as part of the costs of health reform."

Corporations are already restructuring in response to health care costs. The difference is that they are now divided between those that provide private insurance and those that don't. "You have got to remember that the current system has plenty of unintended consequences of its own," Reischauer said.

The CBO analysis assumes that lower-paid workers would gradually migrate to smaller employers because of the economic value of the subsidies.

For example, in a city where the prevailing wage for janitors is $15,000 a year, a big employer with a sizable number of higher-paid employees would have to pay an additional health care premium of $2,000 or so for each new janitor it hired, the CBO calculates. But a small custodial contractor with fewer than 25 employees and no white-collar workers would pay a premium of only about $500 because of the payroll cap.

All other things being equal, the subsidy would make it possible for the contractor to bid for the big company's custodial work at less cost than the company was paying to do the work itself.

The value of the subsidy could trickle down to workers if the contractor decided to pay his janitors more than the $15,000 prevailing wage.

Or it might trickle down to consumers if the big company reduced its prices as its operating expenses declined. In either case, taxpayers would be paying the subsidized portion of the health premium.

For higher-paid employees and their bosses, the incentives could work in the opposite direction. For a small, subsidized firm, the presence of one or more highly paid professionals on the payroll would reduce the value of the government subsidy, since it would be based on a percentage of total wages paid. But at bigger firms, where total premiums are not expected to hit the 7.9% payroll ceiling, big salaries would not necessarily increase health care outlays.

"You could end up with a situation where a company like Microsoft, which has lots of highly paid workers, will spin off its janitorial service to take advantage of subsidies, while a company like McDonald's, which has lots of low-wage workers and only a few high-paid executives, will spin off its professional staff into a separate entity to avoid higher costs," said one White

House official. "We don't know how much of that will take place."

Reischauer predicts that small firms might eliminate highly paid jobs by doing such things as contracting out for advertising and legal work, allowing them to shut down in-house departments.

White House officials say labor market distortions are among the first issues they will attempt to address as they try to respond to the CBO analysis of the Clinton plan.

The most likely modification is one the Clinton health care task force considered, but rejected, as it developed its plan last year, according to one Administration official.

The premium subsidies could be channeled to individual workers who qualify, rather than being funneled to corporations to cover their overall payroll costs. That would eliminate the incentive for firms to divide themselves along subsidized and non-subsidized lines.

White House officials said they originally rejected that idea largely for political reasons: It would let rich law firms and investment companies enjoy the benefits of having some of their lower-paid workers receive subsidies.

But fixing one unintended consequence could lead to yet another.

"It is things like this that make me a gradualist when it comes to public policy," Penner said. "This plan, after all, is the equivalent of creating not one, but several new federal entitlement programs all layered on top of each other. And we are all just making guesses about what this plan would do."

LANGUAGE: ENGLISH

LOAD-DATE-MDC: February 15, 1994

CBO ESTIMATES:
TALKING POINTS

VALIDATES PRIMARY GOALS OF HEALTH REFORM:

1. It proves that we can guarantee all Americans private health insurance -- and provide coverage to 39 million additional Americans -- by 2000, while at the same time *reducing* total health expenditures.
2. It confirms that we will be able to dramatically lower health expenditures over the long run -- $30 billion in the year 2000 and $150 billion in the year 2004.
3. And, finally, it validates the fact that the President's approach will lead to overall deficit reduction in the long term. It's report maintains that: *"CBO believes that the proposal holds the promise of reducing the deficit in the long term."* [CBO, *"An Analysis of the Administration's Health Proposal"*, 2/9/94, p. xiii]

WE DIFFER WITH CBO'S SHORT-TERM DEFICIT ESTIMATES, BUT THE DIFFERENCE IS NARROW AND WILL BE WORKED OUT:

- We are encouraged that the Congressional Budget Office agrees that the President's approach to health reform will bring down the deficit over the long term. We do however disagree on the short-term deficit estimates. Our estimates call for about $10 billion of deficit reduction per year for the first five years. CBO estimates that the proposal will add approximately $10 - $12 billion per year to the deficit. This difference is manageable and we will work with Congress within this range to ensure that the proposal is deficit neutral or better. And as CBO itself said: *"The difference between these estimates is small"*. [CBO *"An Analysis of the Administration's Health Proposal"*, 2/9/94, p. xiii]

- We care about reducing the long-term deficit -- and that's what the plan will do. Let's remember that last year at this time, the Administration disagreed with the CBO about its deficit projections for the budget. But we cooperated with them to work out our differences and now we both agree that last year's budget agreement will reduce the deficit even more than either of us originally projected.

EMPLOYER PREMIUMS SHOULD NOT BE IN THE BUDGET:

- We fundamentally disagree that employers' premium payments for their employees' health insurance should be included in the federal budget. This would mean that payments currently made by private employers to private insurance companies on behalf of tens of millions of Americans would suddenly be considered part of the federal budget. These are payments from one private party to another private party. The government will neither collect nor spend this money. This transaction is similar to the requirement most states have today that their residents purchase auto insurance. The resulting payments -- between these people and their insurance companies -- are *not* counted as part of state budgets in any of the 39 states that have this requirement, nor would anyone expect them to be.

DIFFERENCES WILL BE WORKED OUT IN CONGRESS:

- While we do have some differences with some of the individual assumptions and conclusions of the CBO, these differences will be worked out in the Congressional process. Congress will meet this test. There will be adjustments of course as health care moves through the process of meeting our goal -- guaranteeing private health insurance for every American.

AN ANALYSIS OF THE ADMINISTRATION'S HEALTH PROPOSAL

NOTICE

This document is not available for public release until 2:00 p.m. (EST) on Tuesday, February 8, 1994.

The Congress of the United States
Congressional Budget Office

NOTES

Unless otherwise indicated, years referred to in Chapters 1 and 5 are calendar years and years referred to elsewhere are fiscal years.

Numbers in the text and tables of this report may not add to totals because of rounding.

Cover photo by Richard Price/Westlight.

Preface

The Congressional Budget Office (CBO) has prepared this analysis of the Administration's health proposal in response to several Congressional requests. The report contains an overview of the Administration's proposal and an estimate of its effects on national health expenditures and the federal budget. The report also examines the budgetary treatment of the proposal, its impact on the economy, and other considerations affecting the proposal's implementation.

More than 40 staff members in all of CBO's divisions contributed to the analysis contained in this report. Paul Van de Water coordinated the analysis of the Administration's proposal and the preparation of the report. Linda Bilheimer was responsible for Chapters 1 and 5, Paul Van de Water for Chapters 2 and 3, and Douglas Elmendorf and Douglas Hamilton for Chapter 4.

In the Budget Analysis Division, under the supervision of C.G. Nuckols, Paul Van de Water, Michael Miller, and Charles Seagrave, contributors were Paul Cullinan, Alan Fairbank, Scott Harrison, Jean Hearne, Lori Housman, Lisa Layman, Jeffrey Lemieux, Amy Plapp, Patrick Purcell, Kathleen Shepherd, and Connie Takata. In the Health and Human Resources Division, under the supervision of Nancy Gordon and Linda Bilheimer, contributors were B.K. Atrostic, Sandra Christensen, Carol Frost, Julia Jacobsen, Harriet Komisar, Susan Labovich, Carla Pedone, Murray Ross, Karen Smith, Ralph Smith, Cori Uccello, and Bruce Vavrichek. In the Macroeconomic Analysis Division, under the supervision of Robert Dennis and Douglas Hamilton, contributors were Douglas Elmendorf, Angelo Mascaro, Frank Russek, and Christopher Williams; Derek Briggs, Blake Mackey, and Michael Simpson provided able research assistance. Contributors in other divisions of CBO included Jan Acton, James Blum, Leonard Burman, Thomas Cuny, Ellen Davidson, Gail Del Balzo, Mark Desautels, Robert Hartman, Richard Kasten, Rosemary Marcuss, Marvin Phaup, and Robin Seiler.

CBO would also like to acknowledge the significant help provided by the staff of other federal agencies. The Bureau of the Census performed calculations according to CBO's specifications using data from County Business Patterns. The Health Care Financing Administration's Office of the Actuary provided other critical data and professional assistance. Staff from the Office of Management and Budget, the Domestic Policy Council, and the Department of Health and Human Services interpreted the Administration's proposal and explained the Administration's estimates.

Paul L. Houts supervised the editing and production of the report, assisted by Sherry Snyder. Major portions were edited by Paul L. Houts, Sherry Snyder, and Leah Mazade. Jeanne Burke, Sharon Corbin-Jallow, Dorothy Kornegay, Linda Lewis, and Ronald Moore assisted in the typing. Christian Spoor provided editorial assistance. With the assistance of Martina Wojak-Piotrow, Kathryn Quattrone prepared the study for final publication.

Robert D. Reischauer
Director

February 1994

Contents

SUMMARY xi

ONE OVERVIEW OF THE PROPOSAL 1

The Provision of Health Insurance 1
Establishing a Universal Entitlement 1
Health Alliances 2
Health Plans 4
Federal Program Initiatives and Expansions 6
Medicare's Coverage of Prescription Drugs 6
Home- and Community-Based Services for Severely Disabled People 6
Expansions in Medicaid's Coverage of Long-Term Care 7
"Wraparound" Benefits for Low-Income Children 7
Funding for Graduate Medical Education and Payments to Academic Health Centers 8
Expansion of the WIC Program 8
Public Health Service Initiatives 8
Financing Provisions 8
Premiums Paid to Alliances 9
Subsidies 11
Changes in the Internal Revenue Code 12
Reductions in the Medicare Program 13
Reductions in the Medicaid Program 15
Issues of Governance 15
The Role of the Federal Government 16
The Role of State Governments and Alliances 17
The Role of Employers and the Decision to Form a Corporate Alliance 18
The Flow of Funds Through Regional Alliances and Health Plans 19
Controlling Health Care Costs and Limiting the Financial Exposure of the Federal Government 21
Market Forces and Cost Containment 21
Controls on the Level and Rate of Growth of Premiums 24
Limits on Federal Payments to Alliances 24

TWO FINANCIAL IMPACT OF THE PROPOSAL 25

How the Proposal Affects National Health Expenditures 26
How the Proposal Affects On-Budget
Programs and Social Security 27
Health Insurance Premiums 27
Corporate Alliances 30
Subsidies for Employers 31
Subsidies for Families 32
Total Federal Subsidies 32
Changes in Medicare 33
Changes in Medicaid 34
Long-Term Care Benefit 35
Changes in Other Federal Programs 35
Changes in Revenues 35
How CBO's Estimates Compare with
Those of the Administration 35
Subsidies for Employers 36
Other Differences 37
Sensitivity of the Estimates
to Premium Levels 38
Sources and Uses of Funds of the Health Alliances 39

THREE BUDGETARY TREATMENT OF THE PROPOSAL 41

Guidelines for Budgetary
Classification 42
The President's Commission
on Budget Concepts 42
Budgetary Precedents 43
CBO's Assessment 44
Why Should the Health Alliances Be Included in the
Accounts of the Federal Government? 44
Budgetary Concepts and Precedents 45
Fiscal Accountability and Control 47
Public Perception 48
Why Should the Health Alliances Be Shown Separately? 49
Conclusion 50

FOUR ECONOMIC EFFECTS OF THE PROPOSAL 51

Key Aspects of the Proposal That
Would Affect the Economy 53
Universal Coverage 53
Community Rating 53
Controls on Health Insurance Premiums 53
Employers' Responsibilities 53
Subsidies to Employers 53
Subsidies to Early Retirees 53

The Effects on Health Spending by Business 53
Big Cost Reductions Overall for Business 53
Diverse Effects Among Individual Firms 54
Who Bears the Burden of Health Spending by Business? 55
Why Workers Pay for Health Costs 56
How Savings Might Be Distributed 56
What Would Happen to the Labor Force and Unemployment? 57
Increase Early Retirement 57
Impose an Implicit Levy on Work 58
Encourage Medicaid Beneficiaries to Enter the Labor Force 59
Redirect Employment of Low-Wage Workers 60
What Would Happen to the Structure of the Labor Market? 61
Hours of Work 61
Effect on "Job Lock" 62
Reallocation of Workers Among Firms 62
What Would Happen to the International Competitive Position of the United States? 65
Overall Competitiveness: The Balance of Trade 65
The Competitiveness of Different Firms 66
Conclusion 67

FIVE OTHER CONSIDERATIONS 69

Institutional Capabilities and Resources 70
Information Requirements 71
Requirements for Establishing Payment Parameters 72
Requirements for Managing the Quality of Care 73
Requirements for Administration and Operations 73
The Effects and Sustainability of Controls on the Rate of Growth of Premiums 74
Conclusion 76

APPENDIX Summaries of Recent Health Care Analyses by the Congressional Budget Office 79

TABLES

2-1. Projections of National Health Expenditures Under the Administration's Health Proposal, by Source of Funds 26

2-2. Estimated On-Budget and Social Security Effects of the Administration's Health Proposal 28

2-3. Estimates of Medicare Program Savings Under the Administration's Health Proposal 33

2-4. Differences Between CBO's and the Administration's Estimates of the Administration's Health Proposal 36

2-5. Sources and Uses of Funds of the Health Alliances 38

3-1. Suggested Budgetary Display of the Administration's Health Proposal, Fiscal Year 2004 50

4-1. Effects of Community Rating and Requiring Firms to Pay on the Health Insurance Costs of Private Employers, by Industry, 1992 55

BOXES

1-1. Health Plans Offered Through the Department of Defense, the Department of Veterans Affairs, and the Indian Health Service 3

1-2. Controlling the Level and Growth of Premiums 22

4-1. Inefficiencies in the Current Health Care System 52

4-2. Sorting of Workers in the Administration's Proposal 63

Summary

The Health Security Act is a comprehensive proposal to provide a universal entitlement to health insurance for a broad range of services and to slow the growth of spending for health care. To achieve these goals, it would fundamentally restructure the current health care system, changing requirements and incentives for employers, consumers, insurers, and providers of care. Because of the magnitude of these changes, the full impact on the health care system is extremely difficult to predict.

The Administration's proposal would redesign the current system of financing for health care, while building on its existing employer base. All employers would be required to pay premiums on behalf of their employees, and all individuals and families--except Medicaid beneficiaries and others with very low income--would be required to pay at least part of their premiums. Subsidies would be available to help employers and low-income families meet these obligations and would also be available for retired people ages 55 to 64.

To strengthen the demand side of the health care marketplace, the proposal would establish regional purchasing alliances through which most people who worked for firms with 5,000 or fewer full-time employees would obtain health coverage, as would most other people under age 65 who had no connection to the labor force. Larger firms, firms participating in multiemployer group plans, rural electric cooperatives and telephone cooperative associations, as well as the U.S. Postal Service, would be entitled to establish their own corporate alliances. Medicare beneficiaries would generally remain outside the alliance system. States could choose to opt out of the regional alliance system entirely and establish a "single-payer" system of health care financing, in which the state would pay all providers directly.

Consumers would normally have access to a choice of health plans of different types--including at least one fee-for-service plan--that would be offered through the alliance in the area in which they lived. All plans would offer a standard package of benefits, which would be slightly more generous than the average plan currently offered by employers. To ensure that consumers could make informed choices about those plans, alliances would provide much more information about the plans they offered than is typically available today.

The primary objective of the proposal is to ensure that health coverage would be available at a reasonable price to everyone and that people could not be denied coverage because of their health status. Accordingly, strict requirements would be placed on the enrollment procedures that health plans could employ, requiring plans (within the limits imposed by their capacity and financial constraints) to accept all applicants, and prohibiting plans from excluding people because of preexisting medical conditions. A plan's premiums could not vary for any reason other than the type of family being insured, a requirement known as community rating. (Premiums for plans offered by corporate alliances could, in addition, vary among geographic areas.)

People entitled to Medicaid benefits because they also receive cash welfare payments would continue to obtain coverage from Medicaid but, like almost everyone else, would be enrolled in health plans offered through the regional alliances. Others who currently receive Medicaid benefits would lose that coverage, but most of them would be eligible for subsidies for their premiums.

The proposal would also expand several federal programs and institute new ones. Important among these provisions are coverage of prescription drugs for Medicare beneficiaries, the provision of "wrap-around" health care benefits for low-income children, and a new program to provide home- and community-based services for severely disabled people.

Financing for these initiatives and the subsidies that the federal government would pay to alliances would come from a variety of sources. They would include several new revenue measures, increases in income and payroll tax receipts generated by the change in the mix of employee compensation that would occur under the proposal, reductions in the Medicare and Medicaid programs, and assessments on premiums. States would also make maintenance-of-effort payments to alliances, reflecting their reduced obligations for Medicaid under the proposal.

To lower the rate of growth of health care spending, the proposal would establish a complex mechanism for limiting the growth of premiums for the standard benefit package--an approach that, if carried out as intended, would almost certainly be effective on that score. The proposal would also attempt to limit the obligations of the federal government for subsidy payments, but that endeavor would be less likely to succeed.

Uncertainty of the Estimates

Estimates of the interactive effects of so many complex changes to an industry that encompasses one-seventh of the economy are highly uncertain. Assumptions, used by the Congressional Budget Office (CBO) and other analysts, about people's behavioral responses to new incentives are frequently based on research evidence from small changes in the existing marketplace. In the case of the Administration's proposal, however, the entire marketplace and the configurations of the actors within it would be changing, and there is no precedent for estimating the effects on health spending or the economy.

Estimating the effects of any proposal to restructure the health care system is particularly difficult because, inevitably, the transition from the old to the new system would take several years. Focusing on the effects of proposals in their early years is, therefore, not very meaningful; it is the long-term impacts, when new coverages would be fully phased in and the system stabilized, that are important. Unfortunately, the uncertainty surrounding cost estimates increases significantly in the out-years. Thus, although CBO believes that the most important estimates presented in this paper are those for 2004, they are also the most uncertain.

Financial Impact of the Proposal

National health expenditures would rise in the initial years of the Administration's proposal--an inevitable consequence of expanding health insurance coverage to the uninsured, increasing the generosity of the benefits that many insured people currently receive, and expanding home- and community-based services for the disabled. Over time, however, the combined effects of lowering the rate of growth of health insurance premiums and the cuts in the Medicare program would dominate. Thus, CBO projects that national health expenditures would fall $30 billion below the current CBO baseline by calendar year 2000, and would be $150 billion (7 percent) below that baseline in 2004.

The effects on the federal budget deficit show a similar pattern. The increase in the deficit is estimated to reach slightly more than $30 billion in 1998, the first year in which all states would be participating in the system, and then begin to fall. It would rise again in 2001 and 2002 because of two additional factors in those years: increases in the generosity of the standard benefit package that would occur in 2001, and the subsidies, beginning

in 2002, of state and local governments in their role as employers. By 2004, however, the estimated effects on the deficit are negligible, and CBO believes that the proposal holds the promise of reducing the deficit in the long term.

CBO's estimates of the effects of the proposal on the deficit differ only modestly from those of the Administration. Because the Administration developed estimates for the 1995-2000 period, comparisons for the out-years, which are more important, cannot be drawn. For the six-year period from 1995 through 2000, though, the Administration's estimates indicate that the proposal would reduce the deficit by about $60 billion. In contrast, CBO estimates that the deficit would increase by more than $70 billion over that period. The difference between these estimates is small, however, compared with the uncertainty surrounding the budget projections.

The primary difference between the two estimates stems from the amount of subsidies for employers, with CBO's estimate being considerably higher than the Administration's--by $25 billion in 2000, for example, or about half of the difference in the estimates of the effects on the deficit in that year. The estimates of subsidies for employers differ for three major reasons. CBO's estimates of premiums for the standard benefit package are higher than the Administration's, and estimates of these subsidies are extremely sensitive to the estimates of premiums. CBO also assumes that low-wage workers would cluster in firms that received subsidies, a factor not explicitly taken into account in the Administration's estimates of subsidies. Finally, CBO has used a different methodology than the Administration, one that captures more of the variation in average wages among firms.

Effects on the Economy

Although the Administration's proposal would make fundamental changes in the current health care system, the overall economic impact of those changes might not be large. Because the proposal would involve substantial redistributions within the economy, however, the impact on business costs and employment might be significant for individual firms and people. Similarly, though the proposal would have little predictable effect on national saving and investment, or on the balance of trade, some businesses could see their ability to compete with foreign firms either improving or worsening.

The proposal would retain much of the current central role of employers in the health insurance system, requiring that a large part of health insurance premiums be paid in the first instance by employers. But businesses' costs for health care would be significantly reduced overall, both because the proposal would provide substantial subsidies to firms and because it would limit the growth of premiums. For example, the total premiums employers pay for active workers would drop by about $20 billion in the year 2000.

Although overall costs would go down, for some employers--particularly those that do not currently offer health insurance--costs would increase. Changes in costs could also be pronounced among firms that currently offer insurance. They would rise for some businesses--especially those with young and relatively healthy work forces--as a result of the provisions for community rating. Conversely, businesses that now face high health care costs--because they are small and have little clout in the insurance market, have older or sicker work forces, or hold substantial responsibilities for retirees--would see lower costs.

Those employers facing an increase in their premiums would probably shift most of the added cost to their workers by reducing cash wages, much as occurs now in firms that offer health insurance. Similarly, employees of firms that would pay less would receive higher wages.

For several reasons, the proposal would also affect people's decisions about whether they wanted to seek work or to stay home. For instance, the proposal would guarantee insurance for early retirees and directly subsidize the cost of that insurance. In other words, older people would no longer have to work simply because they needed access to affordable health insurance. A substantial number

would probably prefer the pursuits of early retirement to work, if their health costs were not a concern.

The proposal might also tempt some other workers to leave the labor force. With universal coverage, health insurance would be available even to nonworkers--in some cases at no additional cost. And the requirement that employers pay insurance premiums for all workers, whether or not they had coverage through a spouse, would encourage some people to stay out of the labor force, especially when there is already a full-time worker in the household.

In contrast to these voluntary withdrawals from the labor force, fewer minimum-wage workers might be employed, since their employers' costs of compensation would often be much higher. The incentive to hire fewer minimum-wage workers would be mitigated for small, low-wage firms, however, because the proposal would cap their payments for premiums at levels ranging from 3.5 percent to 7.9 percent of their payroll. Moreover, the number of people involved would be small, and the proposed expansion of home- and community-based care would increase low-wage employment.

Other provisions of the proposal would encourage some people to enter the labor force or improve the operation of the labor market. Some Medicaid beneficiaries are currently deterred from seeking work for fear of losing their health coverage. For the same reason, some workers feel locked into their current jobs when they might prefer a different one. The proposal's universal coverage would encourage Medicaid beneficiaries to enter the work force and would end job lock.

Taking together all the provisions that might increase or reduce participation in the labor force, CBO estimates that eventually between one-quarter of a percent and 1 percent of the labor force might prefer to stay home if the proposal was enacted. Correspondingly, gross domestic product (GDP) would also be reduced, though by somewhat smaller percentages. These changes are not large, falling well within the uncertainty of projections of the labor force and GDP over the next decade.

The proposal would have one further effect on the labor market, as the subsidies for small, low-wage firms would encourage firms and workers to reshuffle so that low-wage workers would be largely together in small firms. The incentives for this reshuffling, or "sorting," would be strong. But sorting would also impose two types of economic costs: the cost of disruption as firms reorganized production, and the costs of inefficiency that would occur because the way firms were organized would not be driven solely by production considerations.

Businesses are often concerned that a change of such magnitude as the Administration's health proposal would affect their ability to compete in international markets. There is little reason to expect any change in the overall balance of trade because the proposal would not have any predictable effect on the main factors determining it--the level of saving and investment in the United States. Some firms would gain, however, and some would lose, depending on what happened to their overall labor costs.

Budgetary Treatment of the Proposal

Ever since the outlines of the Administration's proposal have become known, policymakers and the media have expressed considerable interest in how it would be treated in the federal budget. This issue of budgetary treatment is not unique to proposals to restructure the health care system. Every time the Congress considers or enacts a bill that establishes a new program, the Congressional Budget Office and the Office of Management and Budget must consider whether and how it should be treated in the federal budget. For most pieces of legislation, the call is a relatively easy one. But for some bills, such as major health care reform proposals, some ambiguity and considerable complexity accompany that assessment. In this case, CBO strongly believes that the President and the Congress should address the budgetary treatment of the proposal explicitly through legislation. CBO's role in the decision is strictly advisory.

Certain elements of the Administration's proposal are unambiguously federal activities that all agree should be included in the budget--for example, the increase in the tax on tobacco, the subsidies for individuals and employers, the expansion of certain discretionary programs, and the changes in Medicare and Medicaid. But what about the premiums that individuals and employers pay to the health alliances and the payments by alliances to health plans? Are the alliances private or state entities that belong outside the federal budget? Or are they, for most practical purposes, creatures of the federal government, whose income and outgo should all be included in the federal government's accounts?

In answering such questions, budget analysts normally consult two sources for guidance. One is the 1967 *Report of the President's Commission on Budget Concepts*. The other is budgetary precedent. Because of the unique features of the Administration's health proposal, however, neither source provides a definitive answer.

Considering the Administration's proposal in its entirety, CBO concludes that it would establish both a federal entitlement to health benefits and a system of mandatory payments to finance those benefits that represents an exercise of sovereign power. In administering the proposed program, regional alliances, corporate alliances, and state single-payer plans (if any) would operate primarily as agents of the federal government. Therefore, CBO believes that the financial transactions of the health alliances should be included in the federal government's accounts and the premium payments should be shown as governmental receipts rather than as offsets to spending. Nonetheless, because of the uniqueness and the vast size of the program, the budget document should distinguish the transactions of the alliances from other federal operations and show them separately, as is the practice for Social Security.

Conclusion

The Health Security Act is unique among proposals to restructure the health care system, both because of its scope and its attention to detail. Some critics of the proposal maintain that it is too complex. A major reason for its complexity, however, is that the proposal outlines in legislation the steps that would actually have to be taken to accomplish its goals. No other proposal has come close to attempting this. Other health care proposals might appear equally complex if they provided the same level of detail as the Administration on the implementation requirements.

Questions also arise about the capabilities of new and existing institutions to perform their assigned tasks under the proposal, the ambitious schedule for the development of the necessary infrastructure for the system, and the acceptability and sustainability of the proposed cost control mechanisms. These are very legitimate concerns but, again, they are not peculiar to the Health Security Act. Any proposal attempting to restructure the current health care system would face similar issues.

The ramifications of systemic changes to the health care system are quite uncertain; even the outcomes of incremental changes are difficult to predict. As the Congress considers the Administration's proposal and alternatives, both comprehensive and incremental, the inherent uncertainties of change must be weighed against the detrimental consequences of the current system--increasing numbers of people who lack the security of insurance coverage for health care and the rapidly rising costs of that care.

Chapter One

Overview of the Proposal

The primary objective of the Administration's proposal for health care reform, the Health Security Act, is to ensure that everyone has health insurance for a broad range of services. The proposal would establish a universal entitlement to a standard package of benefits to accomplish this goal. Most participants would obtain their insurance through regional or corporate alliances for purchasing health care, although care provided by the Department of Defense, the Department of Veterans Affairs, and the Indian Health Service would remain an option for some people and Medicare would continue. The alliances would offer participants a choice of insurance plans, all of which would cover the same services. Supplementary insurance would be available for services not covered in the standard package and for certain cost-sharing amounts. The costs of the plans would be financed by premiums paid by employers and households, subsidies provided by the federal and state governments, and payments from programs such as Medicaid. The new system would be fully operational nationwide by 1998, but states would have the opportunity to participate as early as 1996.

Another major objective of the proposal is to restrain the growth of health care expenditures. To accomplish this goal, the proposal includes many structural and institutional changes that would encourage competition in the health sector. In addition, it would impose limits on the growth of premiums for the standard package of benefits and modify somewhat the tax treatment of employment-based health benefits.

As part of implementing and financing the new system, the Administration's proposal would also completely restructure the Medicaid program, significantly modify the Medicare program, and fundamentally change many components of both the private and the public systems for financing and delivering health care. But because of its scope and complexity, a detailed description of all elements of the proposal is not feasible in this report. This chapter, therefore, is limited to a summary of the features of the proposal that bear on the new program's likely costs, its appropriate budgetary treatment, and its possible impacts on the economy. It discusses how the proposal would achieve universal insurance coverage, modify existing programs and initiate others, finance the new system, divide responsibilities among governments and the institutions that would be established, and control the costs of health care.

The Provision of Health Insurance

The core of the Administration's proposal deals with defining the insurance coverage it would provide and with establishing the institutions that would be needed to operate the new system.

Establishing a Universal Entitlement

The proposal would guarantee that citizens and certain other people residing in the United States would have health insurance coverage for a standard package of benefits. Access to services in the standard package could not be denied an eligible individual even if the required premium payments were not made, the provider of the insurance coverage went bankrupt, or the institutions responsible for administering the new system failed to fulfill their

obligations. That package would cover the following:

- Hospital services;
- Services of health professionals;
- Emergency and ambulatory medical and surgical services;
- Clinical preventive services;
- Mental illness and substance abuse services;
- Family planning services and services for pregnant women;
- Hospice care;
- Home health care;
- Extended care;
- Ambulance services;
- Outpatient laboratory, radiology, and diagnostic services;
- Outpatient prescription drugs and biological products;
- Outpatient rehabilitation services;
- Durable medical equipment and prosthetic and orthotic devices;
- Vision care;
- Dental care;
- Health education classes; and
- Certain treatments under clinical investigation in approved research trials.

Coverage of some services would be phased in over time. Dental benefits, for example, would be very limited before 2001, and the coverage of mental illness and substance abuse services would also become more extensive in that year.

Although the proposed coverage of most services is comparable with that provided by relatively generous employment-based policies today, there are some differences. The coverage of preventive health services, for example, would be more extensive from the beginning than in most current health plans, as would the mental health and substance abuse benefits when they were fully phased in. By contrast, the prescription drug and hospital benefits in plans with higher cost sharing and (before 2001) the dental health benefits would be less generous than those that many employers currently provide.

Health Alliances

The Administration's proposal would expand the central role employers now play in purchasing health insurance and restructure the market for that insurance. All employers would have to pay part of the premiums for their employees' insurance. Moreover, the demand side of the health insurance market would be reorganized in order to engender greater market power for individuals and small firms, enable people to have a choice of health plans at a reasonable cost, and provide incentives for health plans to compete on the bases of both cost and quality.

To accomplish these goals, the proposal would establish a nationwide system of regional purchasing alliances. Most people who worked for firms with 5,000 or fewer full-time employees, as well as most people who were not in the labor force (including Medicaid beneficiaries), would be required to obtain health insurance coverage through those alliances. Medicare beneficiaries, however, would generally continue their coverage through that program.

Firms with more than 5,000 full-time employees, firms participating in large multiemployer group plans, rural electric cooperatives and telephone cooperative associations, and the U.S. Postal Service would be entitled to establish separate corporate purchasing alliances. Full-time employees of firms that did so would have to purchase their coverage through their firm's corporate alliance unless they had a spouse who worked for an employer that participated in a regional alliance. Such two-worker families could choose to obtain their insurance through either the corporate or the regional alliance.

Federal civilian employees would obtain their coverage through regional alliances starting in 1998, and the Office of Personnel Management (OPM) would make available to them one or more supplementary plans. OPM would also develop one or more plans that would supplement Medicare's benefits for retired federal workers and their dependents.

People who are now eligible for health coverage through certain federal agencies would still be able to receive their standard benefits through those agencies. Active-duty members of the armed forces would continue to receive their health benefits from the Department of Defense (DoD). Their dependents and military retirees could also obtain coverage through the DoD system if its resources permitted. Indians could obtain coverage through the Indian Health Service and veterans through the Department of Veterans Affairs system. Box 1-1 describes these aspects of the proposal.

Regional Alliances. These entities would be established by the states as either nonprofit organizations or state agencies. They would have nonoverlapping jurisdictions that could be a portion of a state or an entire state but could not cross state boundaries or

Box 1-1.
Health Plans Offered Through the Department of Defense, the Department of Veterans Affairs, and the Indian Health Service

In general, individuals who are currently eligible for health services from government agencies could receive their standard benefits through health plans offered by those agencies. Unlike the current situation, however, people selecting a government plan could not simultaneously participate in another plan covering the standard benefit package.

The Secretary of Defense would establish one or more Uniformed Services Health Plans that would cover at least all the items and services in the standard benefit package. Active-duty personnel would be required to enroll in those plans, for which they would pay minimal amounts. Other people eligible for military health care would have the choice of enrolling in a military plan if one was available, a plan offered by a regional or corporate alliance (for those under age 65), or Medicare (for those age 65 and over). Premium payments and other cost-sharing requirements for people who elected to enroll in military plans could not exceed the family share of premiums and cost-sharing amounts in health plans offered through regional alliances.

Military health plans would receive premium payments from Medicare on behalf of people enrolled in the Supplementary Medical Insurance program who selected a military plan. Conversely, the Department of Defense might make premium payments on behalf of people who were eligible for military plans but elected to participate in other plans.

In a similar manner, veterans could elect to enroll in health plans established by the Department of Veterans Affairs (VA). Those plans would be required to offer all the items and services in the standard benefit package, and they would also provide certain additional services specifically related to service-connected conditions. These additional services would be available to all veterans now eligible for them, regardless of whether they enrolled in a VA plan.

Low-income veterans and veterans with service-connected disabilities who enrolled in VA plans would not have to pay premiums or cost-sharing amounts, but most other veterans would pay amounts based on rules established by the regional alliance in the area in which the VA plan operated. VA health plans would be authorized, but not required, to enroll family members of VA enrollees subject to their paying the required premiums and cost-sharing amounts. Veterans who chose to enroll in other health plans would have no premiums paid on their behalf by the VA. VA plans would be eligible for reimbursement from Medicare, but only on behalf of participants who were eligible for Medicare, who also had no service-connected disabilities, and who were not defined by the VA as having low income.

The Indian Health Service (IHS) would also sponsor plans covering the standard benefit package for eligible Indians, who would not have to pay premiums or cost-sharing amounts. Family members who were not otherwise eligible could enroll in IHS plans but would be required to pay premiums and cost-sharing amounts. The IHS would make no payments for premiums or cost-sharing amounts for Indians who chose to enroll in non-IHS plans.

subdivide a metropolitan area within a state. Each regional alliance is supposed to ensure that its residents would have a choice of the health plans that contracted with the alliance, at least one of which would be a fee-for-service plan. The alliance would also be responsible for ensuring that residents had the necessary information with which to make informed choices and that they enrolled in a health plan.

In general, alliances would be required to contract with all health plans that met the state's standards and wished to offer insurance coverage in their area. Regional alliances could, however, refuse to contract with plans whose proposed premiums exceeded 120 percent of the target for the alliance's per capita premium or that had violated previous contracts with the alliance. The alliances would also collect funds from employers, households, and governments and make payments to the plans chosen by participants. Finally, they would have to meet federal requirements to keep their average premiums at or below specified targets.

Corporate Alliances. Corporate alliances would also have to offer participants a choice of plans, although that choice could be more restricted than in regional alliances. Specifically, corporate alliances would have to offer at least one traditional fee-for-service plan and at least two others of a different type, such as health maintenance organizations (HMOs). Like regional alliances, their responsibilities would include collecting and disseminating information about health plans and their outcomes, as well as meeting federally determined targets for cost containment.

Medicare and the Alliance System. The Medicare program would generally continue to function outside the system of regional and corporate alliances. Enrollment in plans offered through the alliances would be mandatory, however, for people eligible for Medicare if they or their spouse were employed at least 40 hours a month. In addition, some people could elect to stay in certain eligible plans when they became entitled to receive Medicare benefits. Finally, provided that they met certain requirements, states would also have the option to integrate all their Medicare beneficiaries into regional alliances.

Medicaid and the Alliance System. Medicaid beneficiaries who receive cash welfare payments would continue to be covered by Medicaid but would receive services in the standard benefit package through health plans offered by the regional alliances. These beneficiaries could choose any health plan that charged an average or below-average premium, would be absolved of other payments for premiums, and would have special limits on their cost-sharing liabilities. (They could choose a more expensive plan by paying the difference in premiums themselves.) For this group, the federal and state governments would also continue to make payments for benefits that Medicaid now covers but that would not be included in the standard benefit package.

In general, Medicaid beneficiaries who do not receive cash payments would no longer obtain coverage from Medicaid, except for long-term care and cost sharing required by Medicare. Instead, they would benefit both from the same subsidies available to other low-income people obtaining coverage through the alliance and from payments made by their employers if they were working. Almost all children eligible for Medicaid under current law would, however, continue to be covered for those services provided by Medicaid that would not be in the standard benefit package.

The Single-Payer Option for States. The Administration's proposal would allow states to opt out of the regional alliance system and establish a "single-payer" system of health care financing in which the state would pay all health care providers directly. States electing that option would assume responsibility for all people who would otherwise have been in regional alliances. They could also choose to enroll in their single-payer system all Medicare beneficiaries and people who would otherwise have been in corporate alliances.

Health Plans

The proposal envisions that people who obtained their health insurance through alliances would select from a variety of plans that contracted with their alliance, including fee-for-service plans, HMOs, and

point-of-service plans. Some people, however, might not be able to enroll in the plan of their choice--for example, if it was operating at capacity. Plans would have to comply with one of the three cost-sharing schedules that are specified in detail in the proposal--lower, higher, or combination cost sharing--as well as other requirements.

Requirements for Cost Sharing. Higher-cost-sharing plans would impose both specified deductible amounts and coinsurance (calculated as percentages of the providers' fees) according to a national schedule that is specified in the proposal. The use of flat copayments would be prohibited in those plans. Lower-cost-sharing plans would have no deductible amounts and no coinsurance (except for services obtained from providers outside the plan's network of providers). Such plans would charge flat copayment amounts for particular services according to a fixed national schedule also included in the proposal. Cost sharing in combination plans would basically follow the lower-cost-sharing model for in-network services and the higher-cost-sharing model for out-of-network services. In all three types of plans, maximum annual out-of-pocket payments would be the same: $1,500 for an individual and $3,000 for a family.

Requirements for Supplementary Coverage. The proposal would place strict requirements on supplementary health insurance. Insurers could not offer supplementary policies that would duplicate coverage offered in the standard benefit package. Any policies to cover services not included in the standard package would have to be available to all applicants, regardless of their state of residence, subject to capacity and financial constraints.[1]

All plans available through regional alliances would have to offer their enrollees supplementary coverage for cost-sharing amounts.[2] Lower- and combination-cost-sharing plans, however, would offer supplementary coverage only for deductible amounts and coinsurance required for services received from providers who did not have contracts with the plan. Only enrollees in a plan could purchase the supplementary coverage associated with that plan. Premiums for such coverage would have to be the same for all enrollees in a plan, and they would have to reflect the expected increase in use of services that would result from the reduced cost sharing. (Coverage of flat copayments, as opposed to coinsurance, would not be permitted.)

Certification Requirements for Health Plans. In order to contract with a regional alliance, health plans would have to be certified by the state in which the alliance was located. The criteria for certification would encompass standards for quality, financial stability, and capacity to deliver the standard benefit package, as well as requirements relating to community rating, enrollment, and coverage. Those for community rating would prohibit plans from varying premiums among residents of the alliance area (except for variations attributable to different types of families--individuals, couples, single-parent families, and two-parent families). The other requirements would prohibit medical underwriting and limitations on coverage so that no one would have coverage denied or restricted because of a preexisting condition. Those requirements would be stringent; a plan could not terminate or restrict coverage for any reason, even if enrollees did not pay their premiums.[3]

Corporate alliances could either contract with state-certified plans or offer self-insured plans that met the requirements of Title I of the Employee Retirement Income Security Act of 1974. Those plans would have to meet requirements for community rating, enrollment, and coverage just as plans offered by regional alliances would.

Requirements Relating to Essential Community Providers. All health plans would initially be required to enter into agreements to pay essential

1. Membership organizations and employers offering such policies could restrict them to their members and their own employees, respectively.

2. The proposal appears to prohibit corporate alliances from offering supplementary cost-sharing policies, but officials of the Administration have stated that they intended to place no constraints on corporate alliances. In fact, the proposal permits firms that formed corporate alliances to reimburse employees for those expenses.

3. Plans could, however, obtain approval to limit enrollment if they were operating at capacity or in order to maintain their financial stability.

community providers who wished to have such agreements. Essential community providers could either participate in the plan or receive payments from the plan without having a participating provider agreement. Certification as an essential community provider would be automatic for a wide range of private nonprofit and public providers that receive funding under the Public Health Service or Social Security Act.[4] Certified providers would also include Indian health programs and providers of school health services that would receive funding under the proposal, as well as other providers and organizations certified by the Secretary of Health and Human Services (HHS).

The requirement for health plans to contract with essential community providers would end five years after an alliance first offered a health plan. No later than March 2001, however, the Secretary of HHS would recommend to the Congress whether to continue, modify, or terminate the requirement.

Requirements Relating to Workers' Compensation and Automobile Insurance. All health plans that provided services to enrollees through participating providers would be required to provide or arrange for workers' compensation services for their enrollees. Workers' compensation carriers would reimburse health plans for those services. Workers' compensation services could, however, be provided through alternative means if the carrier and the injured worker agreed.

Similarly, enrollees would generally receive from their health plans any medical benefits to which they were entitled through their automobile insurance. Health plans would be required to arrange for referral services, as necessary, to ensure the appropriate treatment for injured individuals. Automobile insurance carriers would reimburse health plans for those services. As with workers' compensation insurance, injured individuals and carriers could agree to alternative arrangements.

4. Those providers would include community and migrant health centers, providers of health services for the homeless and people in public housing, family planning clinics, providers who treat people with AIDS (acquired immune deficiency syndrome) and are funded under the Ryan White Act, maternal and child health providers, and federally qualified health centers and rural health clinics.

Federal Program Initiatives and Expansions

In addition to the new program to provide universal health insurance coverage, the Administration's proposal would create several federal programs and would expand others. Changes in tax policy (discussed in a later section) would also benefit some people, such as those with large expenses for long-term care.

Medicare's Coverage of Prescription Drugs

Starting in January 1996, Medicare's Supplementary Medical Insurance (SMI) benefit package would cover prescription drugs for outpatients. This new benefit would have a $250 deductible amount, 20 percent coinsurance, and an out-of-pocket limit of $1,000. The deductible and out-of-pocket limit would be adjusted each year to ensure that neither the percentage of individuals satisfying the deductible nor the average percentage of enrollees receiving benefits would change.

Several new program requirements would attempt to restrain potential expenditures for prescription drugs. Medicare would limit reimbursement to pharmacists, generally paying them the lesser of the 90th percentile of pharmacies' charges for a particular drug or their acquisition cost plus a dispensing fee. In addition, drug manufacturers would have to provide rebates to Medicare for all nongeneric drugs sold to enrollees.

Home- and Community-Based Services for Severely Disabled People

The Administration's proposal would establish a new grant program for the states to provide home- and community-based services for people with severe disabilities. Although all people who met the disability criteria would be eligible to receive services from this program, it would not be an entitlement for disabled individuals; the number actually receiving services would depend on the amount of

funding appropriated. Federal contributions to the program, which would be phased in over seven years, would be capped, and states would be required to provide some funding.

The total federal budget for the program would be $4.5 billion in fiscal year 1996, rising to $38.3 billion in 2003. Increases in subsequent years would reflect changes in the consumer price index (CPI) and the size of the disabled population. As in Medicaid, a state's share of the funding would vary according to its per capita income, but the share would be much lower than in the Medicaid program, ranging from 5 percent to 22 percent of expenditures for services. If states transferred severely disabled people from the Medicaid program to the new program, thereby reducing federal expenditures for home- and community-based services under Medicaid, the federal budget caps for the new program would increase accordingly.

States would have to impose cost-sharing requirements on all program participants on a sliding scale according to income. Participants with family income below 150 percent of the poverty level would pay nothing; those with family income at or above 250 percent of the poverty level would pay the maximum cost-sharing rate of 25 percent.

Expansions in Medicaid's Coverage of Long-Term Care

Three features of Medicaid's coverage of long-term care would change under the Administration's proposal, two of which would expand eligibility for nursing home services. At their option, states could raise the amount of assets that may be excluded when determining the eligibility of single individuals for nursing home services (the asset disregard) from the current limit of $2,000 to as high as $12,000. In addition, all states would be required to grant eligibility for nursing home services to people who would meet the income and asset requirements for eligibility if their nursing home expenses were deducted from their income. (States currently have the option to grant eligibility to this group of people, but about one-third of the states do not do so.)

A third provision would require all states to allow nursing home residents who are Medicaid beneficiaries to keep at least $50 a month for their personal needs. Because almost half the states now set this allowance at the minimum allowed ($30), some beneficiaries would contribute less to the cost of their care. The federal government would pay for the resulting increase in Medicaid spending.

"Wraparound" Benefits for Low-Income Children

Because the current Medicaid program provides a wider range of services than those included in the standard benefit package, so-called wraparound benefits (apart from long-term care) would be provided to children now eligible for Medicaid. Although these benefits would be financed entirely by the federal government, states' maintenance-of-effort payments would, in effect, pay for roughly their traditional share of costs for these additional services for children in families receiving cash welfare benefits. Thus, the federal government would, in effect, take over the financing of these additional services only for children in families who did not receive cash benefits.

Expenditures for these benefits would be limited, however, based on the combined fiscal year 1993 federal and state spending for them. This limit would be updated to account for changes in the number of eligible children and adjusted by Medicaid-specific inflation factors through 1998 and by the "general health care inflation factor" combined with the rate of growth in the population under age 65 thereafter.[5]

5. For the 1996-2000 period, the "general health care inflation factor" would be the increase in the CPI plus specific amounts--1.5 percentage points in 1996, 1 percentage point in 1997, 0.5 percentage point in 1998, and zero in 1999 and 2000. After 2000, if the Congress did not act, the default factor would be the percentage increase in the CPI combined with the percentage growth in real gross domestic product per capita. (An actuarial adjustment would also be made in 2001.)

Funding for Graduate Medical Education and Payments to Academic Health Centers

The Administration's proposal would restructure the current system of federal subsidies for graduate medical education and academic health centers (and teaching hospitals) to account for the special costs they incur. It would emphasize the training of primary care physicians; both the alliances and Medicare would help to pay for the training of physicians. The proposal would also authorize $200 million a year for graduate nursing education and $400 million a year for Public Health Service programs for the training of minorities and of health professionals specializing in primary care.

A new National Council on Graduate Medical Education would authorize the number of residency positions, by specialty, in graduate medical education programs that received federal funding. At least 55 percent of residents who completed eligible residency programs would have to be in primary care--that is, in family medicine, general internal medicine, general pediatrics, or obstetrics and gynecology. That requirement would first hold for residents entering training in the 1998-1999 academic year.

Funding for the direct costs of approved training programs for physicians would be $3.2 billion in calendar year 1996, rising to $5.8 billion in both 1999 and 2000. In subsequent years, the amount would be the previous year's level increased by the general health care inflation factor. Under the Administration's proposal, Medicare would contribute $1.5 billion in fiscal year 1996, $1.6 billion in 1997 and 1998, and the 1998 level increased by the CPI in subsequent years. Thus, Medicare's relative contribution would probably decline after 2000 since total payments would almost certainly be rising faster than Medicare's contribution.

Medicare's relative contribution to payments to academic health centers (and teaching hospitals) for the indirect costs of graduate medical education would also probably decline over time. Such payments would total $3.1 billion in calendar year 1996, rise to $3.8 billion in 2000, and then increase in subsequent years by the general health care inflation factor. Of these amounts, Medicare would pay $2.1 billion in fiscal year 1996, $2.0 billion in 1997 and 1998, and that amount inflated by the CPI in subsequent years. The remaining funding for both the direct and indirect costs of graduate medical education would come as needed from a 1.5 percent assessment on total premiums paid to regional and multiemployer corporate alliances and from part of the 1 percent tax on the total payrolls of all other employers who established corporate alliances.

Expansion of the WIC Program

The proposal would establish a special Treasury fund subject to discretionary appropriations that, in addition to the regular appropriations for the Special Supplemental Food Program for Women, Infants, and Children (WIC), would help bring the program up to full funding by the end of fiscal year 1996 and then maintain full funding levels. To that end, the Secretary of the Treasury would credit annual amounts to the fund totaling $1.85 billion over the 1996-2000 period. These annual amounts would be available for spending, however, only if the regular appropriation for the year provided new budgetary authority for WIC at levels specified in the proposal.

Public Health Service Initiatives

Activities of the Public Health Service would expand significantly in a number of areas ranging from biomedical and behavioral research to health services for medically underserved populations. To accomplish that expansion, funding for a Public Health Service Initiative would be authorized.

Financing Provisions

Premiums paid by employers and households and payments by the federal and state governments would finance the insurance coverage obtained through the alliances. Employers would pay premi-

ums for all employees who worked at least 40 hours a month.[6] Except for Medicaid beneficiaries who receive cash assistance, nonelderly individuals and families would, in general, be responsible for paying the part of the premium that was not contributed by employers. Families with no workers, or with self-employed workers only, would be responsible for the entire premium for the plans they selected.

Government subsidies would be available, however, for low-income people and for people between the ages of 55 and 64 who had retired from the labor force. Employers, except for those that formed corporate alliances, would be entitled to subsidies that ensured that their payments for health insurance premiums did not exceed certain fractions of their payroll.

The costs of financing the subsidies, expanding the Medicare program, and augmenting various mandatory and discretionary federal health programs would be covered by states' maintenance-of-effort payments, higher SMI premiums, an increase in the excise tax on tobacco, an assessment on the payroll of firms that established corporate alliances, and other assessments and tax changes, as well as by various reductions in the Medicare and Medicaid programs.

Premiums Paid to Alliances

The premiums charged by any health plan offered through a regional alliance for the standard benefit package could vary only by the type of family (individual, couple, one-parent family, and two-parent family); they could not vary by age, sex, or health status. Premiums for plans offered by a corporate alliance, however, could also vary by geographic area. Moreover, the relationship among premiums for different types of families would be fixed and uniform across all regional alliances. For example, the premium for a couple would have to be twice that for an individual in the same plan.[7]

The distribution of premium payments among families and employers would be based on the premise that employers should pay about 80 percent of the premium for full-time workers, and families the remaining 20 percent. The actual proportions would vary, however, for several reasons.

Every family who enrolled in a plan offered by a regional alliance would be assigned an "alliance credit amount" that would equal 80 percent of the weighted average premium in the alliance for that type of family. The weighted average premium for a specific family type would be calculated by averaging premiums for that family type for all the plans in the alliance, weighting the premiums by the number of families of that type in each plan. The family's portion of the premium would be the difference between the premium for the plan selected by the family and the alliance credit amount, subject to various other adjustments, including subsidies.

In contrast, an employer's payment would not equal the alliance credit amount because families contain, on average, more than one worker for whom some employer would be paying premiums. An employer's payments would also not be determined by the premiums of the particular plans selected by its employees. Rather, for full-time workers in a specific family type, each employer's payments would take into account the number of workers of that family type in the alliance--for example, the more two-parent families there were with two full-time workers, the smaller the proportion of the 80 percent employer share any particular employer would have to pay.[8]

More specifically, setting aside the possibility of other adjustments (such as the subsidies for firms that are described below), an employer's payments would be calculated as follows:

6. Two exceptions are children under age 18 and full-time students under age 24 who are dependent on their parents; they would be covered by their parents' policies even if they were employed.

7. Each corporate alliance would have some discretion, but all plans it offered within the same geographic area would have to have the same relationship among premiums for different types of families.

8. In calculating these payments, families with members eligible for Aid to Families with Dependent Children, Supplemental Security Income, or Medicare would be excluded. In addition, an employer's payments would be scaled proportionately for part-time workers, defined to be those who work between 10 and 30 hours per week.

- For individuals, the amount paid by each employer would be 80 percent of the weighted average premium for single individuals in the alliance.

- For couples, the amount would be 80 percent of the total premium payments for couples (that is, the number of couples in the alliance multiplied by the alliance's weighted average premium for couples) divided by the number of couples plus the number of "extra workers." Extra workers are the full-time-equivalent workers in couples with more than one working member. This complicated formulation means that the amount an employer would pay per worker would be reduced as the number of workers in the alliance who were part of a couple rose relative to the number of couples. The reductions in an employer's payments from this adjustment, which derives primarily from the presence of two-worker couples, would be spread among couples without a worker or with only one part-time or full-time worker.

- For both single- and two-parent families, an employer's payments would equal 80 percent of the combined total premium payments for both family types divided by the sum of the number of single-parent families, the number of two-parent families, and the number of extra workers in two-parent families. The aggregation of single- and two-parent families would ensure that an employer paid the same amount for employees in families with children, regardless of the number of parents in the family.

Unlike employers in regional alliances, those that formed corporate alliances would pay an amount similar to the alliance credit amount--namely, 80 percent of the weighted average premium in the corporate alliance for employees in each type of family. (Because the corporate alliance would receive payments for spouses eligible to enroll in other alliances, however, the cost per worker would be reduced in much the same way as for an employer in a regional alliance.) An exception would apply to full-time workers with average annual earnings of less than $15,000 (indexed by the CPI after 1994). For these workers, the employer would have to pay the greater of 80 percent of the weighted average premium or 95 percent of the premium of the lowest-cost plan offered by the corporate alliance that had either lower or combination cost sharing.

Employers in either regional or corporate alliances could pay more than the required minimum amounts on behalf of their employees, but their additional payments for the standard benefit package could not exceed the amount of the family share for the highest-cost plan in the alliance. If an employer chose to pay more, the amounts its employees owed would be reduced correspondingly. Such voluntary payments would have to be equal for all employees in the same type of family, however, regardless of the plans that were selected. Moreover, if the employer's payments totaled more than the premium of the plan selected by the employee, the difference would be returned to the employee (and included in taxable income).

Individuals and families would be responsible for the family share of the premium--that is, the difference between the premium charged by the plan they selected and the alliance credit amount--unless their employers paid more than the required minimum. For most individuals and families, their obligation would average about 20 percent of the total premium costs, but it could be more or less depending on whether they selected a plan with an above- or below-average cost.

Individuals and families with no worker or only a part-time worker would be responsible for some or all of the employer portion, as well as the family portion, of their premiums.[9] The self-employed would pay 7.9 percent of their self-employment income or the employer portion, whichever was lower, even if their family had another full-time worker. (The required percentage would be lower if they were eligible for the subsidies provided to low-wage firms that are discussed below.)

If some employers and families did not pay the premiums they owed to regional alliances, other

9. A family would not be responsible for the employer share if one of its members was employed full time for that month or if two members worked part time and their combined hours of employment totaled at least 120 that month.

employers and families in those alliances would bear the consequences. Each year, an alliance would estimate the amount of premiums that it would be unlikely to collect, adjusted for over- or underestimates in the previous year. It would then adjust the premiums for each type of family by the same proportion in order to collect the desired total from those expected to pay the amounts they owed.

Subsidies

The obligation to pay premiums that the Administration's proposal would place on employers and families would be reduced by a variety of subsidies designed to assist low-income families and employers. These subsidies would be available only for families that obtained, and employers that paid for, coverage through regional alliances. In other words, employers that established corporate alliances would not be eligible for subsidies and would have to keep the amounts paid by their low-income employees below certain limits.

Subsidies for Families. Families receiving benefits from Aid to Families with Dependent Children (AFDC) or Supplemental Security Income (SSI) and people whose income was below a very low threshold ($1,000 in 1994, inflated by the CPI thereafter) would not have to pay the family portion of the premium for plans with premiums at or below the weighted average for that type of family. The family's maximum obligation would rise with income so that at 150 percent of the poverty level a family would pay the lesser of 20 percent of the weighted average premium or 3.9 percent of income. Payments for the family portion would be limited to 3.9 percent of income for all families with income below $40,000 (in 1994, inflated by the CPI thereafter). If no plan with a premium at or below the weighted average was available (for example, because all such plans were at capacity), the family's obligation would stay the same and the amount of the government subsidy would increase.

Subsidies would also be available for individuals and families who were responsible for paying part or all of the employer share of their premiums and for the self-employed who worked part-time and whose remaining obligation for the employer share was not met by the work of other family members. The subsidies would be set on a sliding scale and would be phased out when nonwage income--which includes items such as rents, interest, and dividends--reached 250 percent of the poverty level.

Families in regional alliance plans who had income below 150 percent of the poverty level would also be eligible for reductions in cost sharing if they lived in areas in which no lower- or combination-cost-sharing plan was available at a cost that did not exceed the weighted average premium for their type of family. Families meeting those criteria would be obligated only for the cost-sharing amounts they would have paid if they were enrolled in lower-cost-sharing plans. Regional alliances would pay the remainder to the plans. Special subsidies for cost sharing would also apply to Medicaid beneficiaries, who would pay only 20 percent of the copayment amounts required by lower- or combination-cost-sharing plans. The plans themselves would generally finance the cost-sharing subsidies for Medicaid beneficiaries.

Early retirees who would be eligible for Medicare's Hospital Insurance (HI) benefits when they turned 65 would receive special subsidies for their premiums. (Early retirees would be people between the ages of 55 and 64 who were not employed full time.) Spouses under age 65 who were not employed and other dependents of early retirees would also be subsidized. Retirees in these families would be entitled to government subsidies covering the employer share, leaving them to pay only the difference between the premium for the plans they chose and the alliance credit amount. The subsidies would be reduced by employers' payments for retirees or their spouses who worked part time. If the spouse of a retiree worked full time, no government subsidy would be necessary.

Subsidies for Firms. The Administration's proposal would also place limits on the premiums paid by employers in regional alliances. With the exception of the federal, state, and local governments, which would not be entitled to caps on their premium payments for employees until 2002, an employer's premium payments to regional alliance

plans would generally not exceed 7.9 percent of payroll.[10]

Small, low-wage employers would have lower caps, which would vary according to both the size of the firm and its wage level. The lowest proportion of payroll (3.5 percent) would be paid by firms with fewer than 25 full-time-equivalent employees and average annual wages per full-time-equivalent employee of not more than $12,000. The employers' obligation would increase to reach 7.9 percent for firms with 75 or more employees or average wages of more than $24,000. The proportion of small employers that would be eligible for these additional subsidies would fall over time because the wage thresholds on which the subsidies are based would not be indexed.

Changes in the Internal Revenue Code

Receipts from a variety of sources would finance the Administration's proposal, although some new tax incentives would reduce revenues. Detailed information on the amendments to the Internal Revenue Code contained in the Administration's proposal is available in a recent publication from the Joint Committee on Taxation.[11] Therefore, only a summary of those provisions is provided here.

One provision would increase the excise tax on cigarettes by 75 cents per pack and the taxes on other tobacco products by approximately the same amount per pound of tobacco content. In addition, employers that no longer had to pay for their retirees' health coverage would have to pay a temporary assessment. Employers that established corporate alliances would be required to pay a 1 percent payroll tax, in part to help pay for the federal grants for graduate medical education, nursing education, and academic health centers. Multiemployer corporate alliances and regional alliances would have to pay a 1.5 percent assessment on premiums for the same purposes.

Other provisions would broaden the definition of the tax base for self-employed people. First, more business income of shareholders in S corporations would be treated as "wages" for the purpose of calculating the corporation's eligibility for subsidies of its premiums. Specifically, individuals who owned more than 2 percent of the stock in an S corporation and who participated materially in the business would have their distributive share of the corporation's income from the service-related business treated as wages for this purpose. Likewise, more business income of limited partners in partnerships would be treated as wages for the same purpose. The added income of S corporation shareholders and limited partners would also become subject to employment taxes. These changes would not only reduce subsidies for employers but would also increase payroll tax receipts (as well as future benefits from Social Security and unemployment insurance).

The proposal would also require all state and local employees to pay Medicare's HI payroll tax. Currently, workers hired before April 1, 1986, in states that do not have a voluntary participation agreement with the federal government do not pay this tax, although many are eligible for Medicare's benefits through their spouse or nongovernmental employment. The increase in Medicare's revenue from this proposal would be partially offset by higher future spending because more people would participate in the program.

Two other provisions would reduce subsidies received by high-income retirees. Medicare enrollees with modified adjusted gross income above a specified threshold amount ($90,000 for single taxpayers and $115,000 for married taxpayers filing a joint return) would, in effect, have to pay higher premiums for Supplementary Medical Insurance. The maximum SMI premium for high-income Medicare beneficiaries would cover about 75 percent of the average benefits per enrollee, up from the current level of about 25 percent. In addition, high-income early retirees who would otherwise be eligible to receive subsidies for the employer share of

10. Employers eligible to establish corporate alliances that chose to participate in a regional alliance would not be eligible for these subsidies for the first four years. The subsidies would, however, be phased in during the next four years.

11. Joint Committee on Taxation, *Description and Analysis of Title VII of H.R. 3600, S. 1757, and S. 1775 ("Health Security Act")*, JCS-20-93 (December 20, 1993).

their health insurance premiums would be required to pay that share themselves.

The Administration's proposal would leave the tax treatment of employers' payments for health benefits largely untouched until 2004. As under current law, the proposal would allow the exclusion from employees' incomes of employers' payments for the standard benefit package and for cost-sharing amounts under the standard package, including premiums for cost-sharing supplements. But the proposal would expand the exclusion for employers' payments for qualified long-term care insurance.

Beginning in 2004, employer-paid premiums for supplementary coverage of additional services would no longer be excludable from employees' income for income tax and payroll tax purposes. In keeping with that provision, beginning in 1997, coverage provided through flexible spending accounts would be tax-exempt only for benefits related to the standard package. Also beginning in that year, employers generally could not include health benefits in "cafeteria" plans.

If employers chose to pay more of their employees' premiums than the minimum required, they would have to make equal voluntary payments for all employees in the same type of family. Thus, the employer's total payment could exceed the total premium of the plan selected by an employee. In such a case, the employee would be entitled to a cash rebate that would be subject to both income and payroll taxes.

The proposal also would expand the income tax subsidy for health insurance purchased by the self-employed; it would do so by making permanent and later increasing a tax deduction for health insurance premiums. The proposal would reinstate the 25 percent deduction that expired at the end of 1993 and increase it to 100 percent of premiums for the standard benefit package beginning in 1997 (or 1996 if the state had begun participating in the new system).

By contrast, the proposal would put tighter limits on deductions for taxpayers who prepaid their health insurance premiums. If taxpayers made those premium payments or other payments for medical care, the benefits from which would extend for more than a year after the payment, that amount would be treated as having been paid on a pro rata basis over the period in which the benefits were received. That provision would preclude taxpayers from claiming a large tax deduction for a lump-sum payment for future health benefits.

Three tax provisions related to long-term care would lower revenue. One such provision would provide tax relief for individuals with high expenses for long-term care, and another would offer a tax subsidy to encourage people to purchase private insurance for long-term care. Taxpayers could claim an itemized deduction for spending on qualified long-term care services provided to themselves, their spouses, or dependents for which they had not been reimbursed, if those expenses plus their other qualified medical expenses exceeded 7.5 percent of their adjusted gross income. Premiums for qualified long-term care policies would also count as qualified medical expenses for purposes of itemized deductions. And as mentioned above, the exclusion of an employer's payment of premiums for qualified long-term care policies from an employee's income would be expanded; benefits received from such policies would also be excluded from income.

Other tax provisions in the Administration's proposal include changing the tax treatment of accelerated death benefits under life insurance contracts, providing tax incentives to encourage primary care physicians to practice in areas designated as having a shortage of health professionals, and giving tax credits for personal assistance services for disabled workers.

Reductions in the Medicare Program

A major part of the funding for the proposal would come from reductions in the Medicare program. Some of them would affect the Hospital Insurance program, some would affect the Supplementary Medical Insurance program, and some would affect both. (Increases in SMI premiums for high-income enrollees were discussed above because they would be collected through the income tax system.)

Spending for the HI program would be reduced primarily because payment rates to providers would be lower than under current law. Specific provisions of the proposal would:

- Reduce the updates to the per-case rates used by Medicare's prospective payment system (PPS), which pays for inpatient hospital services, for fiscal years 1997 through 2000;
- Eliminate the adjustment to PPS payments for the indirect costs of patient care that are related to hospitals' medical education programs--although a portion of the amount that would have been paid under this adjustment would be transferred to the fund for academic health centers;
- Reduce the base payment rates for capital-related costs of inpatient hospital services and reduce the updates applied to those payment rates for fiscal years 1996 through 2003;
- In states that were participating in the proposed new health care system, revise and, on average, reduce the PPS payment adjustment for hospitals that treat a disproportionately large share of low-income patients; and
- Reduce the updates to some payment rates for skilled nursing facilities in fiscal year 1996.

The largest reductions in spending for the SMI program compared with current law would result from lower payments for physicians. The specific provisions would:

- Establish goals for cumulative expenditures for physicians' services. Currently, the target rate of growth for each year is based on the prior year's actual rate of growth in outlays for physicians' services, without regard to the prior year's target rate of growth. Under this proposal, the growth target for outlays for physicians' services would be built on a designated base-year target (fiscal year 1994) and updated annually for changes in enrollment and inflation but not for actual growth in outlays above or below the targets for prior years.
- Institute a new system for setting the target rate of growth for payments to physicians. The new system would both substitute the average rate of growth in real gross domestic product (GDP) per capita (plus 1.5 percentage points for primary care services only) for a measure of the change in the volume and intensity of services provided by physicians during the previous five years, and eliminate the annual percentage reduction known as the performance standard factor.
- Eliminate the floor on the reduction permitted in the default update for physicians' payment rates. Currently, there is no upper limit on increases in physicians' fees under the default update formula, but fees cannot decrease by more than 5 percentage points.
- Reduce the conversion factor for the fee schedule for services (except for primary care) provided by physicians by 3 percent in 1995. The conversion factor is a dollar amount that converts the fee schedule's relative value units into payment amounts.
- Limit payments for physicians' services provided by medical staffs at high-cost hospitals, effective January 1, 1998. This proposal would establish limits on Medicare's payments for physicians' services per inpatient hospital admission, similar to limits on payments for hospital services.
- Limit total payments for certain outpatient hospital services to Medicare's approved amounts, effective July 1, 1994. Medicare enrollees' coinsurance liabilities for hospitals' outpatient services are now based on the hospitals' actual charges rather than on Medicare's (typically lower) approved amount for the services. Because Medicare usually pays 80 percent of the approved amount, hospitals often receive more than the total approved amount. This provision would reduce Medicare's payments for hospitals' outpatient services by the amount of patients' extra payments for coinsurance.

- Require Medicare beneficiaries to pay 20 percent coinsurance for all laboratory services, effective January 1, 1995. Medicare currently does not require copayments for clinical laboratory services, although most other SMI services are subject to a 20 percent coinsurance requirement.

- Establish a competitive acquisition process for magnetic resonance imaging tests, computerized axial tomography scans, oxygen and oxygen equipment, laboratory services, and other items at the discretion of the Secretary of HHS, effective January 1, 1995. If competitive bidding did not reduce average prices for those services by at least 10 percent, the Secretary would reduce Medicare's approved fees for those services to accomplish the same goal.

The provisions that would affect both Hospital Insurance and Supplementary Medical Insurance are quite diverse. They would:

- Retain Medicare's role as a secondary payer for disabled employees and employees with end-stage renal disease (who would be insured through their firms). Under current law, Medicare would become the primary payer for those enrollees as of 1999.

- Establish new standards for Medicare's payments to HMOs and competitive medical plans with risk-sharing contracts. Currently, Medicare pays 95 percent of the average adjusted per capita cost (AAPCC) for Medicare enrollees in each county. The program would establish a range around the HI and SMI components of the AAPCC, varying from 80 percent of the national average value up to 150 percent for SMI services and 170 percent for HI services. The intent would be to encourage more HMOs to participate in Medicare while establishing reasonable limits on reimbursement in counties whose AAPCC is high.

- Reduce the limits on payments for routine costs for home health services. In past years, Medicare's payments for home health services were limited to no more than 112 percent of average home health costs nationwide. This provision would reduce the limit to 100 percent of median costs nationwide.

- Require beneficiaries to make a copayment of 10 percent of the average costs for home health visits, excluding visits that occurred within 30 days of discharge from a hospital. Currently, Medicare requires no copayment for home health visits.

- Require the Secretary of HHS to contract with "centers of excellence" for the provision of cataract and coronary by-pass surgery and other services to Medicare beneficiaries, thereby expanding current demonstration projects to all urban areas. Medicare would contract with individual centers using a flat payment rate for all services associated with the affected surgical procedures. Patients would be encouraged to use the centers through rebates equal to 10 percent of the government's savings from the centers.

Reductions in the Medicaid Program

The cost of the Medicaid program would be substantially less than under current law. The proposal would terminate coverage for adult beneficiaries who did not also receive cash welfare benefits and would limit the rate of growth of the per capita payments to regional alliances for beneficiaries who did receive cash benefits, as discussed above. In addition, the proposal would end Medicaid's payments to disproportionate share hospitals--those that treat a relatively high proportion of low-income and uninsured patients--when the state began participating in the new system.

Issues of Governance

The Administration's proposal would place new responsibilities on the federal and state governments, create a variety of new institutions, and specify a complex flow of resources among those institutions.

The Role of the Federal Government

The federal government would play the major role in designing and financing the proposed health care system. Many of its functions would be the responsibility of a newly created National Health Board; other important responsibilities would fall to the Department of Health and Human Services and the Department of Labor.

Functions of the National Health Board. The National Health Board would have the mandate to:

- Interpret the standard benefit package;
- Oversee the cost containment provisions for regional alliances and certify that those requirements were met;
- Develop and implement eligibility rules relating to the coverage of certain individuals and families;
- Develop and implement standards for a national health information system for measuring the quality of health care;
- Establish and assume responsibility for a system to manage and improve the quality of care;
- Develop the multiplicative factors for converting premium amounts for individuals into premiums for couples, single-parent families, and two-parent families;
- Develop methods for adjusting premium payments to health plans so that the premiums reflected the health risks of their enrollees;
- Facilitate the development of a system of reinsurance so that plans could protect themselves against the financial consequences of enrolling a disproportionately large number of people with expensive medical conditions;
- Develop capital standards for health plans that contract with regional alliances;
- Develop standards for state guaranty funds, which would be used to pay providers in the event that a health plan offered by a regional alliance failed;
- Establish criteria that states must meet to begin participating in the system and monitor their compliance; and
- Review documents submitted by the states describing their proposed health care systems and approve or disapprove them.

Federal Initiatives to Ensure Compliance by States. The federal government would not only establish most of the criteria that states and alliances would have to meet but would also have to ensure that states met those standards. To that end, federal planning grants would be available to assist states in setting up their health care systems. The National Health Board, moreover, would have considerable authority to impose sanctions if necessary to enforce the standards. If it determined that a state's noncompliance resulted from the actions of a particular regional alliance, the board could order that alliance to comply and take additional measures to assure that it did so. The board could also require the Secretary of Health and Human Services to reduce federal payments to states for items such as academic health centers and health services research as a sanction for noncompliance. If, however, the board determined that a state was sufficiently far out of compliance that people's access to health services would be seriously jeopardized, the Department of Health and Human Services would take over the operation of that state's system. (The federal government would impose a 15 percent surcharge on total premiums in those circumstances.)

Oversight of Regional and Corporate Alliances. The Department of Health and Human Services would oversee the financial management of the regional alliances. Accordingly, the department would develop standards and conduct periodic audits relating to the alliances' enrollment of eligible individuals, their management of subsidies for premiums and cost-sharing amounts, and their overall financial management.

The Department of Labor would assume major responsibility for oversight of corporate alliances and employers in regional alliances. In particular, it

would ensure that employers in regional alliances paid their share of premiums, withheld and paid their employees' family share of premiums, and submitted timely reports. The department would also temporarily take over any insolvent self-insured corporate alliances; for that purpose, it would establish an insolvency fund to which self-insured corporate alliances would be required to contribute when funds were needed.

Federal Payments. The U.S. Treasury would make payments for several purposes. In particular, the government would be the main source of subsidies for low-income families, employers, and retirees. It would also finance a package of wraparound benefits for low-income children who were previously eligible for Medicaid, as well as pay the federal share of the restructured Medicaid program. In addition, funding would be required for program expansions such as Medicare's coverage of prescription drugs and initiatives such as home- and community-based services for severely disabled people.

The Role of State Governments and Alliances

Although the structure and standards for the proposed health care system would come largely from the federal government, the states and alliances would have the major responsibility for the day-to-day operation of the system. States would also have to help finance the new system.

Responsibilities of State Governments. Each participating state would be required to:

- Submit a document to the National Health Board describing the health care system the state proposed to establish;
- Establish one or more regional alliances, designating the geographic area that each alliance would cover;
- Ensure that families in each regional alliance had a choice of plans in which to enroll;
- Ensure that families were credited with any subsidies for their premiums to which they were entitled;
- Establish capital standards for health plans that met the federal requirements;
- Establish standards for financial reporting, auditing, and reserves of health plans;
- Establish the standards for certifying the health plans that regional alliances would offer, including criteria for quality, financial stability, and capacity to deliver the standard benefit package, and certify the plans to be offered;
- Establish a guaranty fund to pay claims and other debts in the event that a plan failed and, after a failure, collect an assessment of up to 2 percent on premiums to repay the obligations of the plan;
- Ensure continuity of coverage for enrollees in health plans that failed;
- Ensure that the amounts owed to regional alliances were collected and paid; and
- Assist regional alliances in establishing eligibility for subsidies of premiums and cost-sharing amounts and assume financial responsibility for errors that exceeded certain limits.

A designated state agency or official would be responsible for coordinating these activities at the state level.

States would also have substantial financial obligations. They would pay the regional alliances for their share of premiums for individuals and families who remained eligible for Medicaid, and they would be responsible for their share of Medicaid's spending on services not included in the standard benefit package for that group.

In addition, states would make maintenance-of-effort payments related to the restructured Medicaid program. Two components of these payments

would be on behalf of people who would lose their Medicaid coverage under the proposal. (Those people would no longer obtain coverage from the Medicaid program, but most of them would receive subsidies for their premiums for the standard benefit package.) One component would reflect 1993 expenditures for services in the standard package, and the other would reflect the part of states' payments to disproportionate share hospitals attributable to this group of people in that year. A third component would be based on fiscal year 1993 expenditures for children who remained eligible for Medicaid, excluding spending for services that would be in the standard package and for long-term care. The 1993 amounts would be updated by Medicaid-specific factors until the first year of a state's participation, and by the general health care inflation factor combined with the projected rate of growth in the population under age 65 thereafter.

Responsibilities of Regional Alliances. The regional alliances, by contrast, would not finance the health care system. Rather, they would serve as conduits of funds from the federal and state governments, employers, and families to health plans. They would be the frontline agencies that contracted with health plans, enrolled individuals and families in plans, and obtained and disseminated information on the performance of those plans. Regional alliances would also calculate the amounts that families and employers would have to pay, determine whether families and employers were eligible for subsidies, and collect payments from them. In addition, regional alliances would have to implement the cost control provisions required by the federal government. That would include establishing fee schedules for fee-for-service plans, unless the state elected to have a single, statewide fee schedule.

Regional alliances would also play an important role in collecting and analyzing data. They would, for example, have to estimate the number of workers in the different types of families; those numbers would be used in determining how much employers would have to pay. In addition, in order to determine the weighted average premium for each family type, each alliance would have to provide information to the National Health Board about the market shares of the different plans with which it had contracts.

All activities of the regional alliances would be paid for by an assessment on premiums. Each alliance would determine that level annually, but it could not exceed 2.5 percent of total premiums.

The Role of Employers and the Decision to Form a Corporate Alliance

Employers would have many of the same responsibilities whether they participated in a regional alliance or established a corporate alliance. In either case, employers would have to pay a portion of the premiums for their employees' policies. They would also have to deduct their employees' share of the premiums from their paychecks and transfer the funds to the appropriate alliance. In addition, all employers would have to provide specified information to their employees and to the regional alliances.

Most firms with 5,000 or fewer full-time employees would have to participate in regional alliances. (Some smaller firms might participate in multiemployer corporate alliances or ones established by rural electric and telephone cooperatives.) Larger firms, however, would have to decide whether to join a regional alliance or set up a corporate alliance after weighing the relative advantages and disadvantages of the two options. Firms would generally have to decide by January 1, 1996. A decision to participate in a regional alliance would be irrevocable; however, the decision to establish a corporate alliance could be reversed at a later date.

Advantages of Corporate Alliances. Large firms might choose to form a corporate alliance for several reasons. Firms that had already established effective programs for containing health care costs might think that they could control health spending better than the alliance system. Firms would also continue to have direct input into the quality of care their full-time employees received. In addition, they would not be responsible for the assessments that employers participating in regional alliances would

have to pay if there was a shortfall in premium payments. Finally, they would not have to pay the 1.5 percent assessment on premiums for graduate medical education and academic health centers that firms in regional alliances would pay. (Firms in multiemployer alliances would have to pay the 1.5 percent assessment, however.)

Disadvantages of Corporate Alliances. Despite the advantages of establishing a corporate alliance, significant disadvantages would predominate for many large firms. The most important one would generally be that firms that formed corporate alliances would have to pay a tax of 1 percent on their total payroll and that the tax would begin before the regional alliances were set up. (Firms participating in multiemployer alliances would not be subject to that tax.) Moreover, the effective rate of the tax on the payroll of full-time employees enrolled in plans offered by the corporate alliance would be higher than that, because the wages of part-time employees would be in the tax base but the employees would not be eligible to participate. (They would have to enroll in plans offered by the regional alliance, and the firms would have to make the appropriate payments to regional alliances on their behalf.)

Furthermore, a firm that established a corporate alliance would not be eligible for the cap on its premium payments that would be phased in if it joined a regional alliance. Moreover, its low-income employees who worked full time would not be eligible for governmental subsidies of their premiums, and the corporate alliance itself would generally have to subsidize premiums for full-time employees making less than $15,000 a year.[12] A firm that established a corporate alliance and chose to self-insure might also have to make periodic contributions (of up to 2 percent of annual premiums) to the insolvency fund established by the Secretary of Labor for self-insured health plans offered by corporate alliances.

Large firms that had self-insured in the past would probably experience considerably more regulation under the proposal. In addition to the federal requirements for health plans offered by corporate alliances that have already been discussed, the Secretary of Labor would specify financial reserve requirements that those alliances would have to meet. Their fee-for-service plans would have to use the same fee schedules as plans in their corresponding regional alliances. The growth rates of their premiums would be subject to essentially the same limits as those of the regional alliances. Finally, in addition to greater regulation, such firms might find themselves with relatively little power in markets dominated by large regional alliances.

Employers' Obligations for Retirees' Health Benefits. Regardless of whether they participated in corporate or regional alliances, all firms that were paying more than a specified threshold for retirees' health benefits on October 1, 1993, would continue to have obligations to those retirees and most of their dependents. When the subsidies for early retirees commenced in 1998, those employers would be required to pay 20 percent of the weighted average premium for the appropriate type of family. That obligation would continue only as long as members of that cohort remained eligible for the benefits of early retirees.

Because of the large financial windfall that firms with extensive obligations to retirees would gain under the proposal, all employers with health care costs for retirees aged 55 through 64 in 1991, 1992, or 1993 would also be subject to a temporary annual assessment. That assessment, which would be paid each year from 1998 to 2000, would equal one-half of either the average annual health care costs for retirees in the 1991-1993 period (increased by the medical care component of the CPI from 1992 on) or the estimated reduction in retirees' health care costs for the year--whichever was greater.

The Flow of Funds Through Regional Alliances and Health Plans

Regional alliances would receive funds from multiple sources, which they would then allocate to health plans and to other uses. The proposal specifies who would bear the financial responsibility in

12. No subsidy would be required if the employer's contribution covered at least 95 percent of the premium of the most economical plan that did not have higher cost sharing.

particular circumstances if outflows from alliances exceeded inflows.

Sources of Funds for Regional Alliances. Regional alliances would receive payments from the following sources:

- Payments (reflecting appropriate reductions because of subsidies) from employers;
- Payments (reflecting appropriate reductions because of subsidies) from families for the family share and, in some cases, for part or all of the equivalent of the employer share;
- Risk-adjustment payments from firms that were eligible to form corporate alliances but decided to join regional alliances;[13]
- Payments from corporate alliances for part-time employees and for employees in two-worker families who chose to participate in plans offered by regional alliances;
- States' payments for AFDC and SSI beneficiaries, who would make up the continuing Medicaid population;
- States' maintenance-of-effort payments, including those made on behalf of low-income people who would no longer be eligible for the restructured Medicaid program; and
- Federal payments for subsidies and for Medicare beneficiaries who were enrolled in plans offered by the regional alliances, as well as the federal share of Medicaid payments for AFDC and SSI beneficiaries.

Although Medicaid beneficiaries would be enrolling in plans offered by the alliances, Medicaid's payments to alliances on their behalf would not be related to the actual premiums of those plans. Rather, the payments would generally be 95 percent of what Medicaid would have paid in 1993 for the services in the standard benefit package, updated by Medicaid-specific inflation factors until the first year of the state's participation, and by the general health care inflation factor thereafter. (Those amounts would be estimated separately for the AFDC and SSI populations.)

Federal payments for subsidies would, in effect, be residual payments based on the difference between an alliance's payment obligations and amounts receivable from all other sources. As discussed below, however, the proposal specifies certain shortfalls between inflows and outflows that would not be considered federal responsibilities and would not be included in the calculation of those residual amounts.

Uses of the Regional Alliances' Funds. The funds of the regional alliances would be used primarily to make payments to health plans and to pay the alliances' administrative costs. Regional alliances would also pay the federal government 1.5 percent of total premiums in order to help the government finance academic health centers and graduate medical education. In addition, these alliances would make payments to corporate alliances for two-worker families who elected to enroll in a plan offered by the corporate alliance rather than in one offered by the regional alliance.

Health plans would not, however, receive their actual premium amounts. Instead, they would receive a per capita amount for each enrollee; that amount would be based on a weighted average of the final per capita premiums the plans had negotiated with the alliance and the amounts that Medicaid would pay for the AFDC and SSI populations. The weights would reflect the relative size of those populations in the alliance as a whole.

Regional alliances would also adjust the per capita amounts to reflect the risk status of each plan's enrollees. The risk adjustments would be designed to protect plans that enrolled people whose expected use of services was higher than that in the alliance as a whole. Risk adjustments could also be made for plans that enrolled disproportionate numbers of AFDC or SSI beneficiaries. Plans would, however, have to absorb part of the cost sharing

13. If people who would have been covered by plans offered by the corporate alliance were at greater risk than others covered by the regional alliance's plans, the firm would pay risk-adjusted premiums for the first four years. That adjustment would be phased out during the next four years.

they would generally require of participants, because Medicaid beneficiaries would pay only a small portion of it.

Allocation of Risk for Administrative and Estimating Errors. The payment obligations of regional alliances could exceed their receipts for a variety of reasons. Short-term problems with cash flow could result from administrative problems, disparities in the timing of receipts and payments, and estimating errors.

The federal government would not accept financial responsibility for cash flow problems arising from administrative errors that exceeded certain limits; such errors would occur primarily in determining eligibility for subsidies. Alliances could borrow from HHS for shortfalls resulting from such errors, but the states--not alliances--would have to repay the loans through increases in their maintenance-of-effort payments.

Regional alliances could also borrow from HHS for shortfalls arising from disparities in the timing of payments and receipts or from errors in estimates of the factors used to determine their inflows and outflows. These factors would include the number of extra workers in couples and two-parent families, the proportion of AFDC and SSI beneficiaries in the alliance, the distribution of families in different risk categories, the amount of premiums that would not be collected, and, under certain circumstances, the distribution of enrollment in plans with different levels of premiums. The loans would be repaid through reductions in future federal payments to the alliance.

In the first year of operation, however, no alliance could borrow more than 25 percent of its estimated total premiums from HHS. In subsequent years, an alliance's total outstanding loan amount could not exceed 25 percent of its premiums in the previous year. The Secretary of the Treasury would be authorized to advance funds to HHS to cover loans to regional alliances, but the total balance of advanced funds could not exceed $3.5 billion at any time. Regional alliances would also be able to borrow in the private credit markets, but they would be prohibited from using tax-exempt financing.

Controlling Health Care Costs and Limiting the Financial Exposure of the Federal Government

Besides ensuring universal coverage, the other major goal of the Administration's proposal is to control the rate of growth of health spending and, as a corollary, to limit the financial exposure of the federal government. The proposal employs a two-pronged approach to controlling costs: reliance on market forces and, as a backstop mechanism, federal control of the level and rate of growth of premiums. It also attempts to limit federal payments to alliances for subsidies.

Market Forces and Cost Containment

Competition among health plans in a regional alliance is one mechanism through which the proposal intends to control costs. Under the proposal, however, health plans would compete on a different basis than they do today. Those in a regional alliance would not be able to compete on the basis of the benefits they offered, as do current plans, because they would all be required to offer the same standard package of benefits, including standardized cost sharing, to all their enrollees. Moreover, supplementary policies to cover additional services would generally have to be available to any applicant, subject to capacity and financial constraints. Plans would therefore compete on the basis of the quality and convenience of their services and on the level of their premiums.

Families purchasing health coverage through a regional alliance would have incentives to select less expensive plans because the payments that employers would have to make would be independent of the plans their employees selected. In principle, families with workers who selected plans with premiums above the weighted average in the alliance would have to pay more than 20 percent of the premium, and those selecting plans with premiums below the weighted average would pay less than 20

percent. (That might not always be the case because of other adjustments, such as subsidies for low-income families, or because the employer paid more than the minimum required.) Families for whom no employer was paying premiums, including nonretiree families with no workers, would also have strong incentives to choose plans with lower premiums. They would have to make a trade-off, however, if the lowest-cost plans had higher cost sharing.

Box 1-2.
Controlling the Level and Growth of Premiums

The controls on premiums would be implemented differently in regional and corporate alliances. The National Health Board would establish the initial maximum per capita premium that would be permitted in each regional alliance; it would also set limits on its growth. In contrast, corporate alliances would experience controls only on the rate of growth of their premiums.

Setting Initial Premiums for Plans in Regional Alliances

The following steps describe the process for establishing and enforcing the initial level of premiums for regional alliances in states that chose to enter the system in 1996.[1]

The National Health Board would set a baseline target for the national per capita premium based on expenditures for the standard benefit package in 1993. These expenditures would, however, exclude spending for groups such as beneficiaries of Aid to Families with Dependent Children, Supplemental Security Income, and Medicare.

The target would also reflect expected increases in use of services by people who were uninsured or had coverage that was less comprehensive than the standard benefit package, declines in uncompensated care, anticipated reductions in use resulting from higher cost sharing, and cost-sharing amounts that would be required for services covered by the standard package. It would also include an allowance of up to 15 percent to cover the administrative costs of health plans and alliances and existing state taxes on premiums for health insurance. The board would inflate the 1993 national baseline target to 1995 using an inflation factor based on the rate of increase of health spending by the private sector but not more than 15 percent over the two-year period.

By the beginning of 1995, the board would adjust the 1995 national baseline target to establish a target for each regional alliance that would be operating in 1996. The adjustments would account for variations among alliances in health spending, insurance coverage, and spending by academic health centers. To obtain the 1996 targets, the baseline amount would be increased by each alliance's inflation factor. That factor would be the general health care inflation factor adjusted to reflect changes between 1995 and 1996 in the health status and demographic characteristics of each alliance relative to changes in the nation as a whole.

Health plans in a state that was planning to start participating in 1996 would then submit their bids for the per capita premium to each regional alliance in which they wished to operate. Each plan's bid would reflect its estimate of the average per capita premium for the standard benefit package in a particular alliance. Plans submitting bids would do so with the understanding that the board could, under circumstances described below, subsequently lower their bids, and they would have to accept any such reduction.

Following a negotiation period during which health plans might voluntarily lower their bids, each regional alliance would submit its final bids for the per capita premium from their health plans to the National Health Board for review. The board would use information from the alliance to estimate its weighted average bid; each plan's bid would be weighted by the expected enrollment in that plan. The result for each alliance would then be compared

1. A similar process would be followed for alliances that began in 1997 or 1998.

Comparison shopping by consumers would be easier because the regional alliances would provide information about factors such as the quality of care provided by each plan, and consumers would no longer be concerned about differences in benefit packages that were hard to detect. Annual open-enrollment periods would also facilitate moving out of plans that consumers found unsatisfactory.

with the target for that alliance's per capita premium.

If the weighted average bid exceeded the target for the alliance, the board would notify the alliance that it was not in compliance. It would also notify all plans whose bids were above the target that they would face compulsory reductions in their per capita premiums if they did not lower them voluntarily. The reductions would be a percentage of the amount that their bids exceeded the target and would be designed to lower the weighted average bid to the target. Plans with bids under the target would not be affected.

Any plan that chose not to lower its bid voluntarily would have its per capita premium--that is, the amount that would determine its funding from the alliance--reduced by the board. As a consequence, the plan would be required to lower its payments to providers. Those cuts in payments would reflect the proportional reduction in the plan's premium, adjusted for the anticipated increase in the volume of services that would result from the lower payments.

Limiting the Growth of Premiums

After its first year of participation, a regional alliance's target for the per capita premium would be the target for the previous year updated by that alliance's inflation factor. This inflation factor could differ in two ways from the definition used in the initial year. First, it would reflect any changes in the demographic characteristics of the regional alliance that occurred because a corporate alliance had terminated and its members had enrolled in the regional alliance. A second adjustment would occur if the actual per capita premium for the alliance exceeded its target in any year as a result of more people enrolling in high-cost plans than expected. In this case, the alliance's inflation factor would be reduced for the next two years so that health spending in the alliance would be reduced during the two-year period by enough to offset the higher expenditures made in the previous year.

After the initial year, changes would also be made in the procedure for determining the amounts by which bids for the per capita premium would be reduced for a regional alliance that did not comply with its target. To determine the extent to which a plan's bid was too high, the board would compare the current bid with the following amount: the previous year's bid plus the premium target for the current year, less either the premium target or the weighted average bid, if that was lower, for the previous year.[2] Bids submitted by new plans would be compared with the target for the alliance's per capita premium. The remainder of the procedure would be the same as in the initial year.

For corporate alliances, the cap on the rate of growth of premiums would be based on a comparison of the rate of growth of the three-year moving average of per capita spending with the rate of growth of the three-year moving average of the general health care inflation factor. In 2001, corporate alliances would have to start reporting their average per capita expenditures for the previous three years to the Secretary of Labor. If the rate of growth of the spending measure exceeded the rate of growth of the inflation measure in two years out of three, the alliance would be terminated and its members would enroll in plans offered by their regional alliances.

The board also would estimate targets for per capita premiums for single-payer states. If per capita spending for the standard benefit package in those states exceeded the targets, the states would be required to reduce payments to providers accordingly.

2. In the event that the plan's bid for the previous year had been reduced involuntarily, the amount of that reduction would also be subtracted.

Furthermore, limiting the exclusion of employer-paid insurance premiums from employees' income would heighten consumers' awareness of costs once the new system was fully phased in. Employer-paid premiums would be excluded until 2004, however, and then only employer-paid premiums for policies covering additional services would be included in employees' taxable income. Moreover, the proposal would substantially expand the income tax subsidy for premiums paid by the self-employed, further limiting the effectiveness of market forces in containing costs.

Controls on the Level and Rate of Growth of Premiums

To supplement the effects of market forces in containing health care costs, the proposal includes provisions for federal control of premiums for the standard benefit package. The principle underlying the proposed controls is that the national per capita premium for the standard benefit package should increase each year by no more than the general health care inflation factor. For the period from 1996 through 2000, the values of that factor would be the increase in the CPI plus specified amounts--1.5 percentage points in 1996, 1.0 percentage point in 1997, 0.5 percentage point in 1998, and zero in 1999 and 2000. After 2000, if the Congress did not specify new inflation factors, the default factor would be the percentage increase in the CPI combined with the percentage growth in real GDP per capita. (Adjustments would also be made in 2001 to account for at least a portion of the increase in the actuarial value of the benefit package that would occur in that year.)

How the controls would be implemented would differ somewhat in regional and corporate alliances. The National Health Board would establish both the initial maximum per capita premium that would be permitted in each regional alliance and the limits on its growth. Corporate alliances, however, would experience controls only on the rate of growth, not the initial level, of their premiums. Box 1-2 (on pages 22 and 23) describes the processes that would be used to set the targets for regional and corporate alliances, as well as the consequences of breaching the targets.

Limits on Federal Payments to Alliances

In a further attempt to limit the federal government's financial exposure, the proposal lists maximum total federal payments to alliances of the following amounts: $10.3 billion in fiscal year 1996, $28.3 billion in 1997, $75.6 billion in 1998, $78.9 billion in 1999, and $81.0 billion in 2000. After 2000, the limit would be the previous year's limit inflated by the increase in the CPI combined with the average annual percentage change in the population for the previous three years and the average annual increase in real GDP per capita for the previous three years.

The proposal also includes the procedures to be followed if federal payments to alliances were expected to exceed the limits. In particular, the President would have to recommend to the Congress policies to resolve the conflict. The proposal also states that these recommendations would be considered in an expedited manner and would not be subjected to the routine procedural hurdles that tend to slow Congressional consideration of legislation. Because the Congress has the constitutional right to make and change its own rules, however, procedural mechanisms cannot guarantee that an issue will be considered. If the Congress took no action, the courts might be asked to decide which portion of the legislation took precedence--payments to the alliances to ensure coverage of the specified benefits or the limits on federal payments.

Chapter Two

Financial Impact of the Proposal

Two of the major objectives of the Administration's health proposal are to slow the growth in overall national health expenditures and to reduce the relentless pressure that spending for major health programs places on the federal budget. Between 1965 and 1993, national health expenditures grew from 6 percent to 14 percent of gross domestic product. The Congressional Budget Office's (CBO's) projections suggest that this figure will rise to 20 percent by 2004 if the current system is not changed. Over the 1965-1993 period, federal spending for health increased from 3 percent to 17 percent of budget outlays. Medicare and Medicaid are the only major federal programs that are expected to grow faster than the economy, and their growth will begin to drive the budget deficit upward again in the second half of this decade.

Initially, the expansion of health insurance coverage in the Administration's proposal would increase national health expenditures, but the limits on the growth of health insurance premiums and the proposed cuts in Medicare would reduce spending for health in the longer run. By 2004, the proposal would hold national health expenditures about $150 billion below the baseline level. CBO and the Joint Committee on Taxation estimate that the Administration's health proposal would increase the federal deficit by a modest amount as the proposal was phased in. But in the longer run--after 2004--it holds out the promise of reducing the deficit.

CBO has published estimates of the cost of two single-payer plans (H.R. 1200 and S. 491) and four bills from the previous Congress and will soon be providing estimates for other pending proposals.[1] Several of those, including the Administration's, would make massive alterations in the current system for financing and delivering health care. Estimates of the effects of such sweeping changes on overall health spending and its components will necessarily be much less precise than estimates of incremental modifications to existing federal programs. Nonetheless, estimates of the effects of different approaches to health reform provide useful comparative information on the relative costs or savings of alternative proposals.

CBO's estimates of the effect of the Administration's health proposal on national health expenditures and the federal budget use CBO's baseline projections as their starting point. *The Economic and Budget Outlook: Fiscal Years 1995-1999* (January 1994) describes CBO's current economic assumptions and baseline budget projections. A CBO memorandum, "Projections of National Health Expenditures: 1993 Update" (October 1993), sets out CBO's baseline projections of national health expenditures. For comparability with the Administration's figures, CBO's estimates assume that the proposal is enacted during 1994 and takes effect on schedule. CBO assumes, as does the Administration, that 15 percent of the relevant population would participate in health alliances in 1996, 40 percent would participate in 1997, and 100 percent would participate in 1998. Finally, the estimates

1. Congressional Budget Office, "Estimates of Health Care Proposals from the 102nd Congress," CBO Paper (July 1993).

assume that the proposed methods for constraining the rate of growth of premiums for the standard benefit package would be completely effective.

How the Proposal Affects National Health Expenditures

Once the Administration's proposal was fully implemented, it would significantly reduce the projected growth of national health expenditures. Its provisions for covering the uninsured, providing better coverage for many people who already have insurance, and establishing a new federal program of home- and community-based care for the severely disabled would increase the demand for health care services. But the limits on the growth of health insurance premiums and the reductions in the Medicare program would hold down health spending. For the first few years after the proposal was in place, the increases in spending would exceed the decreases, and the proposal would raise national health expenditures above the levels in the baseline. From 2000 on, however, national health expendi-

Table 2-1.
Projections of National Health Expenditures Under the Administration's Health Proposal, by Source of Funds (By calendar year, in billions of dollars)

Source of Funds	1996	1997	1998	1999	2000	2001	2002	2003	2004
Baseline									
Private	614	661	712	766	824	886	952	1,022	1,095
Public									
Federal	379	418	460	505	555	610	670	735	807
Health alliances	0	0	0	0	0	0	0	0	0
State and local	169	184	200	216	234	253	273	295	318
Total	1,163	1,263	1,372	1,488	1,613	1,748	1,894	2,052	2,220
Changes from Baseline									
Private	-59	-157	-387	-422	-460	-510	-554	-601	-650
Public									
Federal	5	-6	-49	-68	-78	-84	-93	-108	-127
Health alliances	74	208	542	563	585	635	668	703	740
State and local	-7	-23	-66	-72	-78	-90	-97	-105	-114
Total	13	22	40	1	-30	-48	-75	-110	-150
Administration's Proposal									
Private	555	505	325	344	363	376	398	422	446
Public									
Federal	384	412	411	437	478	526	577	627	681
Health alliances	74	208	542	563	585	635	668	703	740
State and local	162	161	134	145	157	163	177	190	204
Total	1,176	1,285	1,411	1,489	1,583	1,700	1,820	1,942	2,070

SOURCE: Congressional Budget Office.

tures would fall below the baseline by increasing amounts. By 2004, CBO projects that total spending for health would be $150 billion--or 7 percent--below where it would be if current policies and trends continued (see Table 2-1). National health expenditures in 2004 would represent 19 percent of GDP--more than a percentage point below the baseline.

The Administration's proposal would also significantly change the composition of national health expenditures. A substantial amount of spending that is now being financed by private payments and existing government programs would be channeled through new public entities--the health alliances. In 2004, the alliances would collect almost $750 billion in premiums from employers and households, subsidies from the U.S. Treasury, and other revenues and would disburse the same amount in payments to health plans and in other expenses. Under the proposal, private health insurance and out-of-pocket payments would pay for $650 billion less in health spending than in the baseline. And other federal, state, and local government programs would fund almost $250 billion less.

The projections of national health expenditures by source of funds are not intended to portray the effects of the proposal on the budgets of families, employers, or governments. The national health accounts allocate national health expenditures according to who directly pays for the health insurance or services--not according to who ultimately bears the burden. Thus, the Medicare program is counted as a federal activity, although the program is financed by payroll taxes, general revenues, and premiums paid by households and employers. Similarly, spending by the health alliances is shown as a separate category, even though it is financed by premiums from households and employers and payments by federal and state governments.

How the Proposal Affects On-Budget Programs and Social Security

The Administration's health proposal would affect on-budget federal spending in several ways. It would provide federal subsidies for low-income families and certain employers, alter Medicare and Medicaid, establish new benefit programs for long-term care and supplemental services for children, restructure the system of subsidies for graduate medical education and academic health centers, and make changes in numerous other federal programs. In addition, it would raise Social Security outlays by providing subsidies for early retirees and encouraging more people to start collecting benefits before the age of 65.

Higher levels of receipts by the federal government would offset most of the additional spending. The Administration's proposal would increase excise taxes on tobacco products, levy a payroll tax on employers that established corporate alliances, extend the Medicare Hospital Insurance tax and coverage to all employees of state and local governments, exclude health insurance from cafeteria plans, establish a temporary annual assessment on employers that now provide health benefits for early retirees, and make permanent the tax deduction for health insurance premiums of the self-employed. By limiting the rate of growth of health insurance premiums, the proposal would also reduce spending by employers for health insurance, raise earnings or other taxable income by a corresponding amount, and increase collections of income and payroll taxes.

On average, the Administration's health proposal would increase the projected deficit by less than $15 billion a year between 1995 and 2004 (see Table 2-2). In the last few years of that period, however, the proposal's effect on the deficit gradually dissipates. After 2004, the proposal could potentially reduce the deficit.

Health Insurance Premiums

Determining the average premium to be paid to health insurance plans is one of the most critical elements in estimating the cost of federal subsidies. The higher the estimated premium, the higher will be the estimate of subsidy payments by the federal government.

CBO's estimation of the average premium follows the methodology specified in Section 6002 of the Administration's proposal. The estimate proceeds in three steps: calculate the initial amount of health spending in the baseline that would be paid for by premiums collected by the alliances; increase that base amount in proportion to the expected increase in the use of health services by individuals who are currently uninsured or who have coverage that is less comprehensive than the standard benefit package; and divide the result by the number of people covered by alliance premiums. The calculation of the average premium excludes spending on behalf of Medicaid cash recipients, for whom the

Table 2-2.
Estimated On-Budget and Social Security Effects of the Administration's Health Proposal
(By fiscal year, in billions of dollars)

	1996	1997	1998	1999	2000	2001	2002	2003	2004
				Outlays					
Subsidy Payments									
Subsidies for employers	5	17	44	55	58	67	81	92	102
Subsidies for families	6	20	54	67	70	77	83	89	95
State maintenance-of-effort payments	-2	-6	-16	-20	-20	-21	-22	-23	-24
Subtotal	9	30	82	102	108	123	142	158	173
Medicare									
Drug benefit	6	15	16	17	19	21	23	25	28
Program savings	-7	-12	-19	-28	-37	-45	-54	-65	-77
Offset for employed beneficiaries	-1	-2	-6	-8	-8	-8	-9	-9	-10
Other changes	1	1	1	2	2	2	2	2	2
Subtotal	a	2	-8	-16	-24	-30	-38	-47	-57
Medicaid									
Discontinued coverage	-2	-7	-19	-27	-31	-34	-38	-43	-48
Premium limits and DSH cuts	-1	-5	-14	-20	-24	-28	-33	-39	-45
Other changes	1	2	4	1	1	1	1	1	1
Subtotal	-2	-10	-28	-46	-54	-62	-71	-81	-92
Long-Term Care Benefit	5	8	12	16	20	28	37	40	40
Supplemental Services for Children	a	1	2	2	2	2	3	3	3
Medical Education	1	3	4	6	6	6	7	7	7
Public Health Service	2	3	3	2	2	2	2	2	2
Department of Defense	-1	-2	-2	-3	-3	-3	-3	-3	-4
Department of Veterans Affairs	a	a	-4	-5	-5	-5	-5	-5	-5
Federal Employees Health Benefits	a	a	-3	-3	-4	-5	-6	-7	-8
WIC Program	a	1	1	1	1	1	1	1	1
Other Administrative and Start-Up Costs	1	2	1	1	1	1	1	1	1
Social Security	a	a	1	2	2	2	2	2	2
Assessment for Medical Education	-1	-2	-6	-8	-8	-9	-9	-10	-10
Total, Outlays	15	36	54	50	43	51	61	60	53

alliances would be separately reimbursed, and spending for people who would not be participating in health alliances, such as Medicare beneficiaries who were not employed and members of the armed forces on active duty.

CBO's estimate of the base amount of spending includes all baseline private health insurance premiums, subsidies from state and local governments for public hospitals and clinics, half of state and local subsidies for mental institutions, all Medicaid

Table 2-2.
Continued

	1996	1997	1998	1999	2000	2001	2002	2003	2004
				Revenues					
Income and Payroll Taxes on Additional Income	a	1	4	8	12	16	22	28	34
Increase in the Excise Tax on Tobacco	11	11	11	11	10	10	10	10	10
Assessment on Corporate Alliance Employers	1	2	2	2	1	1	1	1	1
Extension of Medicare HI Tax	2	2	2	2	1	1	1	1	1
Exclusion of Health Insurance from Cafeteria Plans	0	1	2	3	4	5	6	7	7
Assessment on Employers for Retiree Subsidies	0	0	3	5	5	2	0	0	0
Deduction of Health Insurance for the Self-Employed	-1	-1	-2	-2	-2	-3	-3	-3	-3
Other Changes	a	2	1	1	1	2	2	3	3
Total, Revenues	14	17	22	29	33	35	40	46	53
				Deficit					
Total Effect	1	20	32	21	10	16	22	14	a

SOURCES: Congressional Budget Office; Joint Committee on Taxation.

NOTES: DSH = disproportionate share hospitals; WIC = Special Supplemental Food Program for Women, Infants, and Children; HI = hospital insurance.

The Administration's proposal would reduce the deficit by $10 billion in 1995.

The figures in the table include changes in authorizations of appropriations and in Social Security that would not be counted for pay-as-you-go scoring under the Budget Enforcement Act of 1990.

a. Less than $500 million.

spending for noncash beneficiaries, and federal Medicaid payments for disproportionate share hospitals. For uninsured people, CBO uses an estimate of induced demand employing the assumptions described in its memorandum "Behavioral Assumptions for Estimating the Effects of Health Care Proposals" (November 1993). The estimate also assumes that the Administration's standard benefit package would initially be 5 percent more expensive than the average benefit of privately insured people in the baseline.

The estimated total premiums and employer shares per full-time-equivalent worker in 1994 for the four types of policies specified in the Administration's proposal are as follows:

	Total Premium	Employer Share
Single Person	$2,100	$1,680
Married Couple	$4,200	$2,315
One-Parent Family	$4,095	$3,033
Two-Parent Family	$5,565	$3,033

These estimated base premiums are assumed to increase annually according to the formula specified in the proposal, including an additional increase of 5 percent in 2001 to cover the expansion of dental and mental health benefits scheduled in that year.[2]

Employers would collectively be liable for up to 80 percent of aggregate premiums (before any subsidies) under the Administration's proposal. Their actual liability would be less, however, because families without qualified workers would themselves be liable for the employer share. In addition, the percentage of premiums paid by employers collectively would not be the same as the percentage paid by a particular employer. Individual employers would actually pay 80 percent of the average total premium only for single workers without children. Because the calculation of the employer share for each worker takes into account the number of extra workers (working spouses) in couples and families, the employers of married people and single parents (whose employer share is calculated in combination with that of two-parent families) would generally pay less than 80 percent of each worker's total premium. For married couples, the employer share would be 80 percent of the total premiums for all couples divided by the number of couples plus extra workers. For one-parent and two-parent families, the employer share would equal 80 percent of the combined total premiums for all families divided by the combined number of families plus the number of qualified extra workers in two-parent families.

For example, employers would pay $2,315 for each member of a married couple who worked full time. If only one spouse worked full time, that person's employer would pay about 55 percent of the total premium ($4,200) for the couple. If both spouses worked full time, each spouse's employer would pay $2,315 to the alliance, and both employers together would pay 110 percent of the total premium.

On average, families would pay 20 percent of the premium, less any subsidies from the federal government, but specific families would pay more or less depending on their choice of plan. In addition, families with no workers would generally be liable for the employer share of the premium for their type of family. CBO's estimate assumes that the payments of employers and families are based on the average premium for each type.

Corporate Alliances

Firms that formed corporate alliances and their full-time, low-income employees would not be eligible for federal subsidies. Therefore, the estimated number of firms with more than 5,000 employees that would elect to form a corporate health alliance is another important factor in estimating the budgetary effects of the Administration's proposal.

The decision to establish a corporate alliance would depend largely on how much a firm thought it could save by staying outside the system of regional alliances. A firm would tend to find it advantageous to establish a corporate alliance if its average employee had a much lower level of health

2. CBO follows the Administration's practice of using premiums for 1994 to illustrate the effects of the proposal. See Domestic Policy Council, *Health Security: The President's Report to the American People* (October 1993), pp. 111-136.

spending than the average participant in a regional alliance. But a firm that established a corporate alliance would also bear several additional costs: a 1 percent tax on its payroll (including the earnings of part-time workers, who must enroll in the regional alliance in any event), subsidies for premiums of full-time workers earning less than $15,000 per year, and the loss of the 7.9 percent-of-payroll limit on premium costs, which would otherwise be phased in over eight years if the firm joined the regional alliance. In addition, because the payroll tax would start in 1996--whereas most regional alliances are not expected to be in place until 1998--many firms that elected to form a corporate alliance would have to pay the tax for two years before receiving any benefit from their decision.

Based on data from the Bureau of the Census's Current Population Survey of March 1993, CBO estimates that the average firm would have to expect savings in premiums of about $800 per employee in 1996 to make it advantageous to establish a corporate alliance rather than enroll in a regional alliance. The firms meeting this condition employ an estimated 23 percent of the eligible employees in large firms. That percentage would decline in later years as corporate managers had a greater opportunity to observe regional alliances in operation and became more willing to make what would be an irrevocable decision to join a regional alliance. CBO estimates that after 2001, corporate alliances would cover 11 percent of the eligible employees in large firms. CBO also estimates that about three-quarters of the employees now covered by multiemployer plans, rural electric and telephone cooperatives, and the U.S. Postal Service, none of which would be subject to the 1 percent payroll tax, would ultimately be in corporate alliances.

Subsidies for Employers

Employers that participated in regional alliances would generally be eligible for federal subsidies that would limit their required premiums to 7.9 percent of their payroll. Small firms with low average annual wages would benefit from limits as low as 3.5 percent of their payroll. The wage brackets for determining eligibility for these larger subsidies would not be indexed for growth in prices or wages.

CBO based its estimate of the amount of subsidy payments to employers on County Business Patterns data for 1990 collected by the Census Bureau. These data cover employment and payroll for 5.1 million firms. CBO has adjusted the data to match total payroll in the national income and product accounts for 1990 and to reflect growth in employment and wages after that year.

An employer's required premiums would depend on the number of its workers who were enrolled in regional alliances and on their family type. Employers would not have to pay premiums for employees who were dependent children under 18 or dependent full-time students under 24, or for employees who worked less than 10 hours a week; employers would pay only part of the employer share for employees working between 10 and 30 hours a week. They would pay the most for workers in one- and two-parent families and the least for single workers. The estimate assumes that the relevant characteristics of each firm's work force match the average for its size and industry, as calculated from the March 1993 Current Population Survey.

These data allow CBO to estimate each firm's liability for premiums as a percentage of its qualified payroll. They also provide estimates of full-time-equivalent employment and average wages per full-time-equivalent employee, which determine the maximum percentage of its payroll that the firm must pay. The estimated federal subsidy is the excess of the firm's percentage liability for premiums over its limit, multiplied by its qualifying payroll.

The final estimate incorporates three adjustments to the figures derived from the County Business Patterns data. It adds subsidies for employers not included in the data--employers of agricultural, railroad, and domestic workers; employers in Puerto Rico; and (after 2001) state and local governments. It removes estimated subsidies for firms choosing to operate a corporate health alliance. And it takes into account incentives for low-wage workers to minimize their premium liability by clustering in firms. As described in Chapter 4, CBO estimates that such clustering, or sorting--including what already appears to be taking place without the in-

centives in the Administration's proposal--would increase the amount of subsidies to employers by 9 percent in 2000 and 14 percent in 2004.

In total, federal subsidies for employers are projected to rise from $5 billion in 1996 to $58 billion in 2000 and $102 billion in 2004. Employers with up to 24 full-time-equivalent employees--which includes over 90 percent of employers but only one-fifth of workers--would receive 44 percent of total federal subsidy payments to employers. This percentage would decline over time, however, as rising wages pushed some small employers out of the higher subsidy brackets. Premium payments would be capped for about three-quarters of all employers, representing over one-half of qualified employment.

The rapid increase in subsidies for employers between 1996 and 2000 primarily reflects the growing number of workers enrolled in regional alliances during this period. Subsidies continue to grow thereafter because employment levels rise, health insurance premiums increase more rapidly than wages, and state and local governments and additional employers electing not to form corporate alliances become eligible for subsidies.

Subsidies for Families

Under the Administration's proposal, families (including single people) who participated in regional alliances would be eligible for a variety of federal subsidies. Families with low total income could receive subsidies for the family portion of the premium. Families with low nonwage income could also receive subsidies for the employer share of the premium, for which the family would be liable if it did not have a full-time wage and salary worker or the equivalent. In 1998 and thereafter, retirees ages 55 to 64 could have the full amount of the employer share of their family's premium subsidized if they would be eligible for Medicare at age 65. Further subsidies would help low-income families pay cost-sharing amounts.

CBO based its estimate of premium subsidies for families on the March 1993 Current Population Survey (CPS). Using the data from the CPS and the rules specified in the proposal, CBO grouped individuals into health insurance units, excluded ineligible units (for example, Medicare beneficiaries who were not employed and people in corporate alliances), identified units that would be subject to special provisions (for example, recipients of Aid to Families with Dependent Children or Supplemental Security Income, early retirees, workers eligible for Medicare, and the self-employed), computed the relevant measures of income and labor force status, and determined the premium liability and subsidy amount for each health insurance unit. The estimate was then adjusted to take account of people missed by the CPS (the so-called undercount) and people not included in the CPS universe, such as institutionalized persons and residents of Puerto Rico.

Subsidies for families would total an estimated $54 billion in 1998, $70 billion in 2000, and $95 billion in 2004. The number of families receiving a subsidy for the family share of the premium would rise from 40 million in 1998 to more than 50 million in 2004. Families receiving a subsidy for the employer share of the premium (such as those with early retirees, self-employed people, or part-time workers) would approach 30 million in 2004. By 2004, half of all families would receive some subsidy.

Total Federal Subsidies

Employers and families would pay regional alliances the premiums they owed, less the amount of any subsidy; the federal government would, in effect, pay regional alliances for the subsidies, reduced by the states' maintenance-of-effort payments to the alliances. Those maintenance-of-effort payments would be based on 1993 spending by the states for standard benefits for Medicaid beneficiaries who did not receive cash welfare payments, payments to disproportionate share hospitals attributable to such beneficiaries, and supplemental (wraparound) benefits for children receiving AFDC or SSI. This amount would be updated by the projected rate of growth of Medicaid spending through the first year of a state's participation in the new program and thereafter by the general health care inflation factor combined with growth of the population.

CBO estimates that federal payments to regional alliances for subsidies would total $82 billion in 1998, $108 billion in 2000, and $173 billion in 2004. Those figures exceed the capped federal alliance payments specified in the Administration's proposal; CBO believes, however, that the caps on payments to the alliances would not be legally binding. Section 9102 of the proposal attempts to limit federal liability for the subsidy costs of the program, but the limitation does not diminish the federal government's responsibilities under the proposal. The proposal would oblige the government both to make subsidy payments on behalf of employers and families and to ensure health coverage for all eligible people. The proposal contains no provisions for limiting those entitlements in the face of a funding gap, other than providing for expedited Congressional consideration of the matter.

Changes in Medicare

The Administration's proposal would cover outpatient prescription drugs under Medicare starting in

Table 2-3.
Estimates of Medicare Program Savings Under the Administration's Health Proposal (By fiscal year, in billions of dollars)

	1996	1997	1998	1999	2000	2001	2002	2003	2004
Reduce Update for Inpatient Hospital Services	0	-1	-2	-4	-6	-7	-8	-9	-10
Reduce Adjustment for Indirect Medical Education	-2	-3	-3	-4	-4	-5	-5	-6	-7
Reduce Payments for Inpatient Capital	-1	-1	-1	-2	-2	-2	-2	-3	-3
Reduce Adjustment for Disproportionate Share Hospitals	a	-1	-4	-4	-4	-5	-5	-5	-6
Base Reimbursement Rates for Physicians on Real GDP per Capita	0	a	-1	-2	-2	-3	-4	-5	-7
Establish Cumulative Expenditure Goals for Physicians' Services	0	-2	-3	-4	-6	-8	-10	-13	-16
Eliminate Formula-Driven Overpayments for Outpatient Services	-1	-1	-2	-2	-3	-4	-5	-7	-9
Impose Coinsurance for Laboratory Services	-1	-1	-1	-2	-2	-2	-2	-3	-3
Raise SMI Premiums (Net savings)	1	1	2	2	a	-1	-3	-6	-7
Limit Payments for Physicians at High-Cost Hospitals	0	0	-1	-1	-1	-1	-1	-1	-1
Change Secondary Payer Provisions	0	0	a	-1	-2	-2	-2	-3	-3
Impose Copayment for Home Health Care	-1	-1	-2	-2	-2	-2	-2	-2	-3
Other Reductions	-1	-1	-2	-2	-3	-3	-3	-3	-4
Total	-7	-12	-19	-28	-37	-45	-54	-65	-77

SOURCE: Congressional Budget Office.

NOTE: GDP = gross domestic product; SMI = Supplementary Medical Insurance.

a. Less than $500 million.

1996. CBO based its estimate of the cost of the prescription drug benefit on the methodology detailed in its study *Updated Estimates of Medicare's Catastrophic Drug Insurance Program* (October 1989). The distribution of spending for prescription drugs by Medicare beneficiaries under current policies was estimated using the 1987 National Medical Expenditure Survey, adjusted for underreporting and for subsequent increases in drug prices and use. Total spending for prescription drugs by Medicare beneficiaries under the proposal was increased to reflect additional demand for drugs stemming from the extended insurance coverage and reduced to take into account the limits that the proposal would impose on drug prices. Medicare would pay for the portion of this spending that exceeded the specified deductible and coinsurance amounts. Of the increase in Medicare spending, 25 percent would be covered by an increase in premiums paid by beneficiaries, and the remaining 75 percent would be covered by general revenues. All things considered, the net cost to Medicare of the prescription drug benefit would reach $19 billion in 2000 and $28 billion in 2004.

As noted in Chapter 1, reductions in Medicare spending would provide a major part of the funding for the Administration's proposal. The proposed savings would grow from $19 billion in 1998 to $37 billion in 2000 and $77 billion in 2004 (see Table 2-3 on page 33). Most of the cuts would be made in reimbursements to hospitals, physicians, and other providers of health care services. Beneficiaries would also be required to pay higher premiums for Supplementary Medical Insurance and part of the cost of laboratory services and home health care. CBO estimated the savings from these provisions by applying the proposed changes in the reimbursement formulas and cost-sharing requirements to its baseline projections for the types of spending that would be affected.

Under the Administration's proposal, people eligible for Medicare who were employed or who were married to a worker would receive their primary coverage through an alliance rather than through Medicare. Medicare would continue to provide secondary coverage for benefits that it covered but that were not in the standard benefit package, including coverage of certain copayments and deductibles. Medicare would also be responsible for paying a portion of the alliance premium for Medicare-eligible individuals who worked part time or retired in the middle of a year. Based on data from the Current Population Survey, CBO estimates that in 1998 this provision would reduce the number of people receiving primary coverage through Medicare by 2.5 million, of whom about 0.7 million would be the disabled spouses of workers. CBO assumes that most of this group would remain enrolled in Medicare's Supplementary Medical Insurance program to receive the secondary coverage that it would provide. On balance, these changes would save Medicare an estimated $6 billion in 1998, $8 billion in 2000, and $10 billion in 2004.

Other elements of the Administration's proposal would increase Medicare spending by about $2 billion a year. Most of that increase would represent payments to the Department of Defense for care provided to Medicare-eligible individuals who enrolled in a health plan operated by the Defense Department.

Changes in Medicaid

Under the Administration's proposal, some people who currently receive certain health benefits from Medicaid would receive them from the alliances or from other programs instead. Medicaid would no longer cover standard benefits for beneficiaries who did not receive cash welfare payments, supplemental services for poor children with special needs, or pharmaceuticals covered by the new Medicare drug benefit. CBO's estimates of the savings from this discontinued Medicaid coverage reflect the baseline projections of spending for these items. The estimated savings would grow from $31 billion in 2000 to $48 billion in 2004.

Medicaid would continue to cover recipients of cash welfare payments, who would receive services through the regional alliances, but federal payments would be cut. Initially, the federal government would pay only 95 percent of what it would have paid under current law. Thereafter, premiums for Medicaid beneficiaries would grow at the same rate as other premiums in the regional alliances. In addition, Medicaid would no longer make payments

for disproportionate share hospitals (DSH). Limiting the growth of premiums and cutting DSH payments would save Medicaid $24 billion in 2000 and $45 billion in 2004.

The Administration's proposal would liberalize eligibility for long-term care benefits, speed up payments for services, reduce administrative expenses, and make other small changes to the Medicaid program. Those changes would, on balance, increase Medicaid spending slightly.

Long-Term Care Benefit

The Administration's proposal would establish a new entitlement program to help states finance home- and community-based care for the severely disabled. The proposal would limit spending for this new program to specified amounts, plus the amount of federal savings for home- and community-based services under Medicaid. CBO assumes that the states would spend about one-quarter of their savings on optional Medicaid services. Net of the savings to Medicaid, this program would cost the federal government an estimated $20 billion in 2000 and $40 billion in 2004.

Changes in Other Federal Programs

The Administration's proposal would also affect several other federal programs. It would establish a new program for poor children to provide supplementary benefits not included in the standard benefit package, restructure the system of subsidies for graduate medical education and academic health centers, expand the activities of the Public Health Service, and fully fund the Special Supplemental Food Program for Women, Infants, and Children. The Departments of Defense and Veterans Affairs would receive payments from regional alliances for health services provided to some members of their health plans. The Federal Employees Health Benefits program would save money from the limits on premiums, which would slow the growth of its spending, and from being relieved of part of its responsibility for subsidizing the health benefits of retirees.

The availability of universal health insurance and the subsidization of health insurance for retirees ages 55 to 64 would encourage some older workers to retire earlier. CBO estimates that these changes would add 215,000 more retired workers ages 62 to 64 to Social Security's benefit rolls in 2000 and would raise Social Security outlays by $2 billion. Over the long term, Social Security would incur no additional costs, because benefits are actuarially reduced for early retirement.

Changes in Revenues

The Joint Committee on Taxation has estimated the impact of the provisions of the proposal that would affect on-budget federal revenues and Social Security payroll taxes. By 2004, more than half of the new revenues would stem from increases in income and payroll taxes on the additional taxable income generated by the proposal. The limits on premiums and other elements of the Administration's proposal would sharply reduce the growth of employer spending for health insurance. By 2004, employers would save about $90 billion for active workers and more than $15 billion for early retirees. The estimate assumes that the lion's share of those savings would be returned to workers in the form of higher cash wages and that most of the rest of the savings would be reflected in higher corporate profits. (These assumptions, which reflect long-established conventions of revenue estimation, are examined in Chapter 4.) Federal revenues would rise because the additional wages and profits would be subject to income and payroll taxation. The additional revenues would total $34 billion in 2004. Other provisions that would significantly increase on-budget and Social Security revenues include an increase in the excise tax on tobacco ($10 billion in 2004) and the exclusion of health insurance from cafeteria plans ($7 billion).

How CBO's Estimates Compare with Those of the Administration

In its budget for fiscal year 1995, the Administration estimates that its health proposal would reduce the deficit by $38 billion in 2000 and by a cumula-

Table 2-4.
Differences Between CBO's and the Administration's Estimates of the Administration's Health Proposal (By fiscal year, in billions of dollars)

	1995	1996	1997	1998	1999	2000
Administration's Estimate of Proposal's Effect on the Deficit	-11	-3	7	5	-18	-38
Differences						
Subsidies for employers	0	2	6	17	22	25
Subsidies for families	0	-1	-1	-1	-1	a
State maintenance-of-effort payments	0	a	a	2	3	3
Medicare drug benefit	0	-1	1	1	1	2
Long-term care benefit	0	a	1	1	1	1
Social Security	0	a	a	1	2	2
Assessment on corporate alliance employers	0	2	3	4	4	4
Exclusion of health insurance from cafeteria plans	0	0	4	6	6	5
Other differences	1	1	-1	-3	2	6
Total Differences	1	5	13	27	39	48
CBO's Estimate of Proposal's Effect on the Deficit	-10	1	20	32	21	10

SOURCES: Congressional Budget Office; Office of Management and Budget.

a. Less than $500 million.

tive total of $59 billion over the 1995-2000 period. (The Administration has not provided estimates for later years.) In contrast, CBO estimates that the proposal would increase the deficit by $10 billion in 2000 and by a total of $74 billion over the six-year period. The two estimates are virtually the same in 1995 but differ by growing amounts after that year. CBO's estimate exceeds the Administration's by about $50 billion in 2000 (see Table 2-4).

Subsidies for Employers

Differences in the estimated cost of federal subsidies for employers account for about half the total difference between the two sets of estimates. In 2000, CBO estimates that such subsidies would cost $58 billion--$25 billion more than the Administration's figure of $33 billion. Three major factors explain the higher CBO estimate: a higher estimate of the average health insurance premium, the assumed clustering of low-wage workers to take advantage of federal subsidies, and a methodology that better accounts for the dispersion of average wage rates among employers.

CBO's estimate of the average health insurance premium under the Administration's proposal is about 15 percent higher than the Administration's estimate. CBO's average premium, however, is virtually identical to that used by Lewin-VHI, Inc., in its recent financial analysis of the Administration's proposal and about 13 percent lower than the actuarial estimate by Hewitt Associates.[3] CBO's

3. Lewin-VHI, Inc., *The Financial Impact of the Health Security Act* (Fairfax, Va.: Lewin-VHI, December 1993), p. 25; testimony of Dale H. Yamamoto and Frank B. McArdle, Hewitt Associates, before the House Committee on Energy and Commerce, Subcommittee on Health and the Environment, November 22, 1993, p. 9.

estimate of premiums is higher than the Administration's because it assumes that the alliance health plans would be responsible for a larger proportion of national health expenditures. For example, compared with the Administration's estimate, CBO assumes that more services for the uninsured, which are now funded by state and local subsidies to public hospitals, would be paid for through alliance plans. CBO also assumes, based on consultations with actuaries, that the standard benefit package would be about 5 percent more expensive than the current average benefit package for insured people. CBO's higher estimate of premiums explains about $15 billion of the difference between the estimates in 2000.

As noted above and explained in Chapter 4, CBO concludes that providing subsidies to employers based on the employer's average wage would create an incentive for low-wage workers to cluster in certain firms. The Administration, in contrast, makes no explicit assumption about the sorting of workers into firms. This difference in assumptions explains another $4 billion of the difference between the estimates in 2000.

The remaining $6 billion difference between the estimates of subsidies for employers stems from differences in estimating methodologies. CBO based its estimate on County Business Patterns data for specific firms. In contrast, the Administration based its estimate on data for people in the Current Population Survey and imputed an average wage per firm to each worker in the CPS sample based on the worker's industry, state of residence, and establishment size. CBO believes that the Administration's method of imputation understates the variation in average wages among firms and therefore substantially underestimates the number of workers in firms that would be eligible for subsidies.

Other Differences

Other differences between CBO's and the Administration's estimates are much smaller. The two estimates of the cost of subsidies for families are quite similar; in 2000, the Administration's allowance for behavioral changes almost exactly offsets CBO's higher premiums.

CBO's estimates of maintenance-of-effort payments by the states are slightly lower than those of the Administration, with the difference reaching $3 billion by 2000. Maintenance-of-effort payments would be based on spending by states in 1993 on behalf of Medicaid recipients who were not beneficiaries of AFDC or SSI or eligible for Medicare. CBO's estimate of the proportion of Medicaid spending that falls in this category is derived from data reported by the states to the Health Care Financing Administration; it is smaller than the figure assumed by the Administration.

CBO and the Administration differ slightly in their estimates of the costs of the proposed Medicare drug benefit and the long-term care benefit. CBO's estimate of the cost of the drug benefit is $2 billion higher than the Administration's in 2000. CBO assumes a higher level of spending for drugs in the baseline, but the Administration assumes a larger increase in demand from the new benefit. CBO's estimate of the long-term care benefit exceeds the Administration's estimate because of CBO's assumption that the states will spend about one-quarter of their savings on optional Medicaid services. Another difference in the two sets of estimates is that the Administration's estimate includes no additional Social Security benefits for early retirees.

The Joint Committee on Taxation (JCT) has estimated that the income from the 1 percent assessment on the payroll of corporate alliance employers would yield only $1 billion in revenues in 2000--$4 billion less than the Administration's estimate of $5 billion. In preparing its estimate, the Administration assumed that most eligible large firms would choose to establish corporate alliances. In contrast, CBO and JCT have projected that firms employing only about 15 percent of eligible employees would be in corporate alliances in 2000. JCT has also estimated that excluding health benefits from cafeteria plans would gain $5 billion less in revenues in 2000 than the Administration has calculated. The difference arises from JCT's assumption that a smaller fraction of the health benefits that could no longer be provided through cafeteria plans would end up as wages.

Sensitivity of the Estimates to Premium Levels

The impact of the Administration's proposal on the deficit is highly sensitive to the assumed level of health insurance premiums in the alliances. The higher the average premium, the greater will be the federal subsidy payments, the smaller the increase in taxable incomes, and the bigger the increase in the deficit. CBO has illustrated this sensitivity by estimating the financial impact of the Administration's proposal under two additional sets of premiums: that of the Administration, which is roughly 15 percent below CBO's, and a set that is 10 percent higher than CBO's.

Using the Administration's premiums, CBO estimates that the Administration's proposal would reduce the deficit in 1999 and later years. The reduction would amount to $17 billion in 2000 and $40 billion in 2004. The reduction in the deficit in 2000 would still be about $20 billion less than the

Table 2-5.
Sources and Uses of Funds of the Health Alliances
(By fiscal year, in billions of dollars)

	1996	1997	1998	1999	2000	2001	2002	2003	2004
Sources of Funds									
Nonfederal									
Employer payments	30	93	239	290	300	318	327	338	352
Household payments	10	30	76	92	94	99	104	107	110
State share of Medicaid	2	6	17	20	21	22	24	25	27
State maintenance-of-effort payments	2	6	16	20	20	21	22	23	24
Subtotal, Nonfederal	43	136	348	421	436	461	477	493	513
Federal									
Subsidies	9	30	82	102	108	123	142	158	173
Federal share of Medicaid	3	8	22	27	28	30	32	33	36
Other federal payments	a	a	6	8	8	9	9	10	10
Subtotal, Federal	12	39	110	137	144	162	183	201	219
Total, All Sources	56	174	458	558	580	623	660	695	732
Uses of Funds									
Payments to Health Plans	54	168	441	537	558	599	635	668	705
Assessment for Medical Education	1	2	6	8	8	9	9	10	10
Alliance Administration	1	4	11	13	14	15	16	17	17
Total, All Uses	56	174	458	558	580	623	660	695	732

SOURCE: Congressional Budget Office.

a. Less than $500 million.

Administration's own estimate, but removing the difference in assumed premiums would eliminate more than half of the total difference between CBO's and the Administration's estimates. If premiums were 10 percent higher than CBO has assumed, the proposal would add substantially to the deficit each year--$52 billion in 1998, $36 billion in 2000, and $38 billion in 2004.

Sources and Uses of Funds of the Health Alliances

Although the Administration's proposal would have only a modest effect on the federal deficit, the flows of funds into and out of the regional and corporate health alliances would be substantial (see Table 2-5). Payments to health insurance plans would constitute by far the largest of the alliances' outlays. Alliances would receive payments of premiums from employers and households and maintenance-of-effort payments and payments on behalf of Medicaid beneficiaries from the states. The U.S. Treasury would also make payments to the alliances for subsidies for employers and households, the federal share of Medicaid, and premiums for federal civilian employees and certain people eligible for Medicare. Alliances would make payments to other alliances in cases in which a household could choose its source of coverage, but these interalliance payments would have no net effect.

Chapter Three

Budgetary Treatment of the Proposal

The *Budget of the United States Government* serves many purposes. Not only is the budget a financial accounting of the receipts and expenditures of the federal government; it also sets forth a plan for allocating resources--between the public and private sectors and within the public sector--to meet national objectives.

Ever since the outlines of the Administration's health proposal became known, policymakers and the media have expressed considerable interest in how it would be treated in the federal budget. Some observers contend that the program would not receive an appropriate degree of scrutiny if the budget did not include all of its financial transactions. If the financial activities mandated by the new program were not part of the budget, they argue, fiscal discipline might suffer: activities that are now in the budget might be transferred to non-budget entities that were not subject to the oversight and restraints characteristically imposed on budget accounts. Others fear that labeling all of the program's financial flows as budgetary might preclude a reasoned consideration of the proposal's merits by raising concerns about the size of the public sector. The choice of budgetary treatment could also affect which Congressional committees are given primary jurisdiction over the proposal.

The issue of budgetary treatment is not peculiar to the health reform initiative. Every time the Congress considers or enacts a bill that establishes a new program, the Congressional Budget Office and the Office of Management and Budget must consider whether and how it should be shown in the federal budget. For most pieces of legislation, this is a relatively easy call. But for some bills, such as major health reform proposals, that assessment is marked by some ambiguity and considerable complexity.

This chapter discusses the appropriate budgetary treatment of the Administration's health proposal, particularly the treatment of the payments to and from the regional and corporate alliances. It first examines the two main sources of guidance on budgetary classification--the *Report of the President's Commission on Budget Concepts* and the current budgetary treatment of programs analogous to the President's plan. It finds that these sources can inform the decision on how to treat the Administration's proposal but by themselves cannot resolve the issue.

The second and third sections of this chapter explain CBO's view: the financial transactions of the health alliances should be included in the accounts of the federal government, but they should be distinguished from other federal operations and shown separately, as is the practice for the Social Security program. CBO bases this view primarily on its judgment that the Administration's proposal would establish a federal entitlement to health benefits and that the mandatory premiums used to finance the new entitlement would constitute an exercise of sovereign power. CBO's view on these matters is only advisory; ultimately, the Congress and the President should explicitly address the issue through legislation to ensure the appropriate public control of and accountability for the transactions of the alliances.

Guidelines for Budgetary Classification

Certain elements of the Administration's proposal are unambiguously federal activities that all agree should be included in the budget--for example, the increase in the tax on tobacco, the subsidies for individuals and employers, the expansion of certain discretionary programs, and the changes in Medicare and Medicaid. But what about the premiums that individuals and employers pay to the health alliances and the payments by the alliances to the various health plans? Are the alliances private or state entities that belong outside the federal budget? Or are they, for most practical purposes, creatures of the federal government, whose income and outgo should all be included in the federal government's accounts?

In answering such questions, budget analysts normally consult two sources for guidance. One is the 1967 *Report of the President's Commission on Budget Concepts*. The other is budgetary precedents. Because of the unique features of the Administration's health proposal, neither source provides an unambiguous answer.

The President's Commission on Budget Concepts

In March 1967, President Lyndon B. Johnson appointed a 15-member commission to advise him on budgetary concepts and presentation. The commission issued its report in October of that year, and the budget that the President submitted in January 1968 reflected most of its recommendations--notably, the institution of a unified federal budget. The commission's proposal to record federal credit transactions in the budget on a subsidy-cost basis was not adopted until 1990, with the passage of the Federal Credit Reform Act. A few recommendations--for example, the use of accrual accounting instead of cash accounting--have never been fully implemented.

Although the *Report of the President's Commission on Budget Concepts* has no legal status, it remains to this day the only authoritative statement on federal budgetary accounting. The commission's most important recommendation was for a comprehensive budget with few exclusions. "To work well," the commission stated, "the governmental budget process should encompass the full scope of the programs and transactions that are within the Federal sector and not subject to the economic disciplines of the marketplace." The commission recommended that "the budget should, as a general rule, be comprehensive of the full range of Federal activities. Borderline agencies and transactions should be included in the budget unless there are exceptionally persuasive reasons for exclusion."[1]

The commission recognized that its recommendation posed "practical questions as to precisely what outlays and receipts should be in *the budget* of the federal government. The answer to this question is not always as obvious as it may seem: the boundaries of the federal establishment are sometimes difficult to draw." The commission proposed a series of questions to help make this determination: "Who owns the agency? Who supplies its capital? Who selects its managers? Do the Congress and the President have control over the agency's program and budget, or are the agency's policies the responsibility of the Congress or the President only in some broad ultimate sense? The answer to no one of these questions is conclusive, and at the margin, where boundary questions arise, decisions have been made on the basis of a net weighing of as many relevant considerations as possible."[2]

The report cited some exceptions, though, to its recommendation of a comprehensive budget. For example, even though the Federal Reserve System is clearly a federal operation, the commission recommended that its receipts and expenditures be excluded from the budget, in part to protect the independence of the nation's monetary authorities. The commission recommended that the local receipts and expenditures of the District of Columbia be excluded as well, even though the District is a federal

1. *Report of the President's Commission on Budget Concepts* (October 1987), pp. 24-25.

2. Ibid.

enclave. The commission further recommended that government-sponsored enterprises be omitted from the budget when such enterprises were "completely privately owned." Because the Administration's proposal shares some of the characteristics of these exceptions but lacks others, no one can be sure how the commission would have treated the health alliances, had they been on the horizon in 1967.

The commission also considered the issue of when to offset receipts against expenditures in presenting the government's fiscal totals. For fiscal year 1993, the Department of the Treasury reported federal outlays of $1,408 billion, federal governmental receipts of $1,153 billion, and a deficit of $255 billion. The figure for governmental receipts includes most of the funds that the government collects (for example, income and payroll taxes). But the budget treats some of the government's income, such as proceeds from the sale of stamps by the Postal Service, as an offset to its outlays.

"For purposes of summary budget totals," the commission recommended, "receipts from activities which are essentially governmental in character, involving regulation or compulsion, should be regarded as receipts. But receipts associated with activities which are operated as business-type enterprises, or which are market-oriented in character, should be included as offsets to the expenditures to which they relate." Among the various items that should be treated as budget receipts the commission listed both employment taxes and social insurance premiums.[3]

Budgetary Precedents

Another way to inform judgment is by examining relevant precedents. Yet this approach is also incomplete, because the Administration's health proposal differs significantly from existing programs and because existing accounting practices are inconsistent.

In one major instance--the unemployment insurance (UI) program--the federal budget includes in its entirety a joint activity of the federal and state governments. The Social Security Act of 1935 created the UI program and established a federal tax liability. Under the program, states are free to set tax rates, benefit levels, and eligibility requirements within certain limits. States that establish a federally approved UI system and impose their own payroll tax receive a partial credit against the federal UI tax. The federal tax pays for federal and state administration of unemployment insurance, 97 percent of the cost of employment services, and 50 percent of the cost of extended benefits during periods of high unemployment in a state. The state and federal taxes alike are deposited in trust funds held by the U.S. Treasury, and the federal budget records all of the funds' revenues and spending.

In other instances, the federal budget includes only part of the cost of a joint federal/state program. For example, if a state establishes a program of Medicaid or Aid to Families with Dependent Children that meets the terms of the Social Security Act, the federal government pays a prescribed share of the costs, and the budget includes only that federal payment. Unlike the case of unemployment insurance, however, the federal government imposes no tax or other penalty if a state fails to establish a Medicaid or AFDC program.

The Coal Industry Retiree Health Benefit Program is part of the federal budget, although its funds do not pass through the Treasury. Established by the Energy Policy Act of 1992, this program guarantees lifetime health benefits for certain miners and their dependents and requires coal companies to pay health insurance premiums to two privately managed trust funds on behalf of those miners, including some who never worked for the companies in question. Even though the benefit plans are nominally private and the federal government plays no role in selecting their trustees, the plans' receipts and spending are included in the federal budget because federal law both requires payment and determines the use of the money.

The budgetary treatment of the promotional boards for agricultural commodities is at odds with that of the Coal Industry Retiree Health Benefit Program. Federal law has established 17 of these boards since 1955. The boards collect assessments

3. Ibid., p. 65.

from domestic producers (and sometimes importers and marketers) and use those funds to promote consumption of a particular commodity, such as dairy products or cut flowers. The Secretary of Agriculture appoints most of the boards, and federal law establishes and enforces payment of the assessments. Yet despite this substantial federal role, the budget does not include the transactions of the boards.

Still other comparisons are possible between the Administration's proposal and various federal regulatory activities. For example, the federal government requires employers to meet conditions governing the wages and hours of workers (under the Fair Labor Standards Act of 1938), occupational safety and health (under the Occupational Safety and Health Act of 1970), and the treatment of persons with disabilities (under the Americans with Disabilities Act of 1990). All of these laws impose substantial costs on employers and may affect the amount and type of compensation that employees receive, but the budget includes none of their costs.

Looking at these budgetary precedents does not resolve the issue of how to treat the Administration's health proposal. The proposal bears a resemblance to all of the programs cited, but it also shows significant differences. Which is the most appropriate comparison? Is the proposal most like the unemployment insurance program, AFDC or Medicaid, the Coal Industry Retiree Health Benefit Program, the promotional boards for agricultural commodities, the mandates of the Americans with Disabilities Act, or some other program? The answer is, again, a matter of judgment. But even if the answer were clear, a practice followed for a program costing $200 million might not be appropriate for one costing $500 billion.

CBO's Assessment

Determining the appropriate budgetary treatment of a program like health reform involves answering not one but a series of questions. Is the program fundamentally governmental in nature, or does the legislation seek to facilitate, regulate, or guide an activity or transaction that remains essentially private? If the activity is primarily governmental, is it a federal activity, a state activity, a shared federal/state activity, or some new hybrid? If the answers to these two questions indicate that the program belongs in the accounts of the federal government, a third question arises: How should the program be displayed in, and controlled through, the budget?

Considering the Administration's proposal in its entirety, the Congressional Budget Office concludes that it establishes both a federal entitlement to health benefits and a system of mandatory payments to finance those benefits. In administering the proposed program, regional alliances, corporate alliances, and state single-payer plans (if any) would operate primarily as agents of the federal government. Therefore, CBO believes that the financial transactions of the health alliances should be included in the federal government's accounts and that the premium payments should be shown as governmental receipts rather than as offsets to spending. Nonetheless, because of the uniqueness and vast size of the program, the budget document should distinguish the transactions of the alliances from other federal operations and show them separately, as is the practice for Social Security. CBO's view, as noted earlier, is solely advisory. The President and the Congress should ultimately resolve the debate over the proposal's budgetary treatment through legislation.

Why Should the Health Alliances Be Included in the Accounts of the Federal Government?

Two factors shape CBO's view that the proposed health alliances should be included in the federal government's accounts--a review of budgetary concepts and precedents and the need to ensure fiscal accountability and control. In addition, the public's perception of the nature of the new program deserves some consideration.

Budgetary Concepts and Precedents

More than a government regulation, the Administration's proposal specifies outcomes, dictates the means by which the outcomes must be achieved, prescribes the financing mechanism that must be used, and enforces the prescribed transactions. The first section of Title I creates a universal entitlement to a set of benefits that are defined in considerable detail. The benefits would not be restricted to those who already receive similar benefits, nor would nonpayment of premiums be grounds for a health plan or health alliance to deny benefits. Thus, the program does more than redefine the terms or conditions of preexisting private transactions, which is how one might characterize the minimum wage, for example.

The Administration's proposal establishes an explicit financing mechanism for the standard benefit package. It requires employers (except those large firms that choose to form corporate alliances), employees, and nonworkers to pay premiums to the regional alliances. A federal entity--the National Health Board--and a set of subsidies specified in federal law would largely determine the levels of those payments. The premiums would be mandatory, although many participants would undoubtedly pay them gladly in return for the program's health benefits, just as many would voluntarily contribute to Social Security in return for that program's retirement, survivors, and disability benefits. The proposal would also require states to make specified payments (for example, Medicaid maintenance-of-effort payments) to their regional alliances.

The National Health Board and the Departments of Health and Human Services and Labor would play important roles in the creation and day-to-day operation of the new health system. The board would approve the states' health care systems, impose sanctions on those systems that failed to meet federal requirements, develop a methodology for risk adjustment and reinsurance, set capital standards for health plans in the regional alliances, develop standards for states' guaranty funds, and oversee and monitor the system. The Secretary of Health and Human Services would develop standards for the financial management of the health alliances, audit the regional alliances, and certify essential community providers with whom plans would have to affiliate. The Secretary of Labor would be responsible for the proper functioning of the corporate alliances and could impose civil monetary penalties for noncompliance.

Although the federal government would play a very large role, the proposal would assign substantial responsibilities--and leave some discretion--to the states, the regional alliances, corporations, and individuals. States would establish and define the geographic boundaries of the regional alliances, ensure that the amounts owed to the alliances were collected and paid, assist alliances in verifying eligibility for subsidies, certify health plans and assure their fiscal solvency, ensure that all residents had access to an adequate choice of health plans, establish a reinsurance program for health plans, and provide a guaranty fund. If they chose, states could assign the responsibilities of the alliances to a state agency. They could also establish a single-payer plan, which would affect the amount of choice offered to the state's residents, the governance of the system, and (within specified limits) the system's financing.

The regional alliances would be charged with making agreements with qualified health plans and offering those plans to the residents of their areas. The alliances would ensure that people enrolled in health plans, collect premiums, determine eligibility for subsidies, evaluate the performance of health plans, ensure that the plans stayed within budget, adjust payments to plans for different levels of risk, establish fee schedules for services, and coordinate activities with those of other alliances. In addition, health plans in the regional alliances would offer participants the option of purchasing supplementary insurance to cover certain cost-sharing requirements of the standard benefit package and could offer supplementary insurance for items not included in the standard package. As proposed, the alliances' income from premiums and their payments to the health plans would not pass through the Treasury's accounts.

Large corporations would be able to establish corporate alliances that would perform the basic functions of regional alliances. Large corporations would also have some discretion in shaping the

options that their corporate alliances offered to employees. The Administration's proposal would impose no limits on the amount a corporation could initially pay for the insurance it provided to its workers, but it does specify the minimum fraction of the costs that the firm would have to pay and the rate by which premiums could grow. The premiums and payments would not flow though the regional alliances, and the subsidies to individuals would be largely the responsibility of the corporation, which would be required to pay at least 95 percent of the costs of insuring its low-wage workers. The proposal would require corporate alliances to offer at least three health plans (including one fee-for-service plan and two others, such as health maintenance organizations), employ community rating, use the same medical fee schedules as the regional alliances, and satisfy much the same requirements for information as the regional alliances.

Individuals in both regional and corporate alliances would have a choice of health plans, and their premiums would vary according to the plan they chose and their income. People would also have the option of purchasing supplementary health insurance.

Are these discretionary aspects of the proposal sufficient to classify the new program as a regulatory activity or a shared federal/state program? The answer to this question is a matter of judgment. No sharp line separates regulatory activities that are outside the budget from governmental activities that are within it. In this case, when the federal government specifies not only an outcome but also how the outcome is to be achieved, limits the ways in which the activity can be financed, makes a substantial financial contribution, and calls for the creation of new institutions to carry out the activity, CBO concludes that the boundaries of regulation have been crossed.

In particular, this appears to be the case with respect to the regional alliances. Federal statute would establish and define these new institutions. The terms and financing of the insurance they offered would be specified by federal law, and their activities would be regulated and monitored by the Departments of Labor and Health and Human Services. This situation differs from cases in which the federal government requires existing institutions--states or businesses--to take on added responsibilities and leaves open the choice of how they would finance them.

The corporate alliances, which have many of the characteristics of private entities, would for all practical purposes be standing in for a governmental or quasi-governmental agency--the regional alliance. If a large corporation chose not to establish its own alliance, it would have to participate in the regional alliances. If a corporate alliance did not comply with federal regulations or became financially insolvent, it could be terminated by the Secretary of Labor. If a state chose to establish a single-payer system, it could deny the large corporations operating within its borders the option of establishing a corporate alliance.

The important role and flexibility afforded to states and regional alliances do not appear to be sufficient to classify the proposal as a shared federal/state program like AFDC or Medicaid. Indeed, the level of federal involvement would far exceed that of existing entitlement grant programs. Regional alliances would be able to borrow from the federal government and would receive start-up grants from Washington. In addition, they would be granted powers that could only flow from federal authority. For example, they would have the power to extract premium payments from businesses in other states that employed their residents, even when those businesses engaged in no activity in the alliance's state. Federal law would establish a complex set of financial flows among alliances. Those flows would cover people who moved either temporarily or permanently, full-time students who attended schools located in other alliance areas, and multiworker families in which one or more workers could be covered by a corporate alliance.

As described in Chapter 1, federal agencies would play an important role in ensuring that states and alliances fulfilled the requirements specified in the proposal. If a state did not establish a system of alliances according to the law, or if the National Health Board terminated its approval of a state's system, the Secretary of Health and Human Services would establish and operate a system of alliances and would impose a surcharge of 15 percent on

premiums to cover additional administrative and other expenses. This backstop is even stronger than the one in the unemployment insurance program, which establishes a federal payroll tax liability that can be largely offset by state unemployment payroll taxes.

The universality of the entitlement distinguishes the Administration's health proposal from programs such as AFDC and Medicaid. In those two programs, states have the option of not participating. (Until 1982, Arizona did not participate in Medicaid.) The Administration's proposal would require everyone to participate; it would also require states to make specific payments to their regional alliances for noncash beneficiaries of Medicaid and for additional benefits for certain children receiving AFDC or Supplemental Security Income.

The significant financial role that payments from the U.S. Treasury would play in the new program reinforces the impression that it would be predominantly a federal, not a state, activity. By 2004, about 30 percent of the payments to the health alliances would be federal subsidies to low-income families and employers, payments for Medicaid beneficiaries, and the like. And the financial role of the Treasury in the regional alliances could grow even bigger if many Medicare recipients and military dependents currently receiving federal health services chose to participate in the alliances instead. In contrast, the states would have a much smaller financial role.

Even the voluntary aspects of the new program do not by themselves resolve the issue of budgetary treatment. The fact that individuals could choose the plan they wanted, and thus the premium they would pay, is balanced by the constraints that federal law and regulation would place on the benefits and the charges. The benefits and cost sharing would be set by legislation, and ultimately the National Health Board would limit the average premium in each area. The voluntary nature of supplementary cost-sharing insurance--people can decide whether or not to purchase it--must be weighed against the fact that federal law would define its scope, coverage, and availability. Moreover, the proposal would require that the premiums for cost-sharing supplements take account of the increased use of standard benefits by those people who had purchased the supplementary coverage. Furthermore, it is worth noting that the federal budget includes many voluntary transactions, not the least of which is physician insurance under Medicare.

On balance, the new program seems to represent an activity of the federal government that relies on the exercise of sovereign power. The universality of the entitlement, the mandatory nature of the premiums, and the major financial participation of the U.S. Treasury outweigh other considerations. Although the states and the alliances would have important roles and responsibilities, they would be acting largely as agents of the federal government.

Fiscal Accountability and Control

The second reason for including the health alliances in the federal government's accounts is the need for accountability and control. Since the alliances would be agents of the federal government, their financial flows should be subject to a level of oversight and control similar to that accorded programs that are included in the federal budget.

It is particularly important that the activities of the health alliances be subject to some fiscal restraints and limits as long as tight controls govern other federal activities. Discretionary appropriations are currently limited by caps on budget authority and outlays. Receipts and direct spending programs are constrained by pay-as-you-go rules. Social Security, which is classified as off-budget, is subject to its own set of rules, which are designed to prevent the depletion of the program's reserves.

The Administration's health proposal would establish many financial flows between the Treasury and the health alliances. Payments would flow from the Treasury to the alliances for subsidies to individuals and employers, for recipients of cash welfare benefits, and for Medicare beneficiaries who chose to stay in an alliance plan. The Treasury would receive payments from the alliances for graduate medical education and for participants who chose to get their health care through plans established by the Department of Defense, Department of Veterans Affairs, or Indian Health Service. If the

activities of the health alliances were not subject to fiscal control, the restraints on federal spending and receipts could easily be circumvented by altering these financial flows or creating new ones.

For example, the Congress could lower the mandatory payments that the federal and state governments would make to the alliances to pay for the health benefits of Medicaid cash beneficiaries from 95 percent of their previous payments to, say, 75 percent. If the alliances were exempted from the budgetary discipline imposed on most other federal activities, cutting those payments would appear to reduce federal spending and would add room on the pay-as-you-go scorecard, even if individuals and employers were required to pay higher health insurance premiums to cover the receipts lost to the alliances.

Similarly, the Congress could require health plans to cover needs and activities that are currently provided through discretionary appropriations, such as nutritional assistance for infants and pregnant women. This move would free up resources under the discretionary spending limits of the budget and make the health alliances bear added burdens if they were not subject to appropriate budgetary controls.

Increasing the limits on the percentage of their payrolls that employers contributed to the regional alliances would appear to have very different effects on the federal government's finances depending on how the budget treated the alliances. If the alliances were included in the government's accounts, higher employer payments would be recorded as an increase in governmental receipts. If the alliances were excluded, any rise in employers' payments would be shown as a spending cut, because it would reduce federal subsidies to the alliances.

Preventing budgetary gamesmanship requires that corporate alliances and state single-payer plans--not just regional alliances--be included in the federal government's accounts. Otherwise, legislation could create the semblance of budgetary savings by expanding the corporate alliances or by creating additional incentives for states to operate single-payer systems. Including the corporate alliances and the state plans would also avoid meaningless changes in the fiscal totals that could arise if several large firms terminated their corporate alliances or if the Secretary of Health and Human Services was forced to take over a state's system of alliances.

The Congress has several options available for controlling the financial activities of the health alliances. It could subject the alliances to the same fiscal controls that govern the rest of the federal government's activities, or set up a separate set of controls for them, or both. Without a full accounting and some sort of control, however, the income and outgo of the health alliances would escape the scrutiny that is essential when the federal government takes resources from individuals and businesses and uses them to meet a national objective.

Public Perception

Some policymakers and citizens may wonder whether including the health alliances in the federal government's accounts defies common sense and the public's perception of the nature of the new program. Why should the government's accounts show transactions that, for most workers, are like those that already occur in the private sector? The answer is that the budgetary status of a federal activity is not determined by whether the private sector provides the same service. Very few federal programs would be included in the budget if the criterion for inclusion were that there be no comparable private spending. Many federal programs that appear in the budget are largely an extension of prior practices in the private sector. For example, loans to businesses and individuals, medical research, and public safety programs are a few of the large number of federal programs that have displaced private spending to some degree.

Many of those people who now have employment-based health insurance might be surprised at first to be told that they had just become participants in a major new federal program, since under the new system they might be able to keep the same health plans that they now have and might enjoy much the same benefits. Currently, employers (or unions) make payments to insurance carriers that reflect both the employers' contributions and the employees' premiums (if any), which are deducted

from the workers' paychecks. In the new system, employers would make the same sorts of payments, but they would make them to an alliance, which would then transfer funds to the health plans that the workers had chosen.

What would differ is that federal law rather than the employer would determine the benefits and premiums. Moreover, the transaction would no longer be voluntary. The employer could not drop or change the terms of the health insurance benefit. Similarly, employees could not opt out of their employment-based plan, as some do now because they do not want to pay their share of the premium or because they are covered under a spouse's policy.

Those people who were receiving employment-based health insurance for the first time would initially be more accepting of the notion that they had become participants in a government program. Their employers, who would suddenly find themselves required to make payments for their employees' health insurance, would undoubtedly feel the same way. Many nonworking and self-employed individuals with adequate incomes who currently choose to remain uninsured would probably conclude that they were part of a government program as well.

Why Should the Health Alliances Be Shown Separately?

Although CBO's analysis has concluded that the health alliances would be more like federal agencies than like state or private entities, it has also found that the Administration's proposal would be unique in its form, size, scope, and complexity. In addition, the funds earmarked for the health alliances are not intended to be used for any other federal program. These features of the proposal argue for showing its transactions separately in the federal government's accounts rather than mixing them with other federal activities.

The institutions and responsibilities that the Administration's proposal would create would be unlike those of any existing federal program. The flows of premiums and spending into and out of the alliances would dwarf the income and outgo of Social Security, which is currently the largest federal program (see Table 2-5). The complexity of the structure would be unprecedented, with regional alliances, corporate alliances, and possibly state single-payer plans interacting with each other and with numerous private health plans, Medicare, Medicaid, the Veterans Affairs and Indian health systems, the Defense Department's health plans for military dependents, and the federal subsidy system. A separate budgetary accounting would make clear the size of the program and its effect on federal receipts and outlays.

Like Social Security, which is treated as off-budget but included in the federal government's consolidated accounts, the Administration's health proposal would be financed from earmarked revenues, except for the subsidies and other explicit payments from the U.S. Treasury and the states. Segregating the finances of the alliances from other federal programs would reflect the earmarked nature of the premiums and highlight the additional subsidies required.

Several practical considerations constitute further grounds for segregating the finances of the health alliances. Unlike the funds of almost all other federal programs, those of the alliances would not flow through the U.S. Treasury. At least initially, then, their financial data--particularly the reports from the corporate alliances--are likely to be of poorer quality than those of programs currently in the budget. The Coal Industry Retiree Health Benefit Program illustrates this point: despite its being in the budget, its funds do not pass through the Treasury, and problems with data collection have thus far prevented its inclusion in the *Monthly Treasury Statement of Receipts and Outlays of the United States Government.*

Table 3-1 illustrates the budgetary display that CBO suggests for the Administration's proposal. Federal outlays for premium and cost-sharing subsidies, Medicare, and Medicaid, and federal receipts from income and excise taxes (see Table 2-2) would be shown on-budget. Changes in Social Security benefits and payroll taxes would be shown off-

budget. The net outlays and nonfederal receipts of the health alliances (see Table 2-5) would be shown in a new off-budget category, the way Social Security is shown today, and included in the federal government's consolidated totals. Because the health alliances are expected to balance their income and outgo, including them in the totals would have no significant effect on the deficit. But the alliances' payments to health plans would swell federal outlays, and mandatory payments of health insurance premiums by firms and individuals would add to federal receipts.

Maintaining a separate accounting for the health alliances would not stand in the way of obtaining a complete picture of the impact of the federal sector on the economy. The consolidated totals would reveal "the full scope of the programs and transactions that are within the federal sector and not subject to the economic disciplines of the marketplace," as the President's Commission on Budget Concepts recommended, and would allow policymakers and the public to evaluate the Administration's proposal in a comprehensive fashion. But keeping the health alliances separate would make clearer the many complex interactions among the proposal's components and would recognize and accommodate the proposal's unique aspects, which prevent it from fitting neatly into any existing budgetary pigeonhole.

Table 3-1.
Suggested Budgetary Display of the Administration's Health Proposal, Fiscal Year 2004 (In billions of dollars)

	Outlays	Receipts	Surplus or Deficit (-)
CBO Baseline			
On-Budget	2,007	1,503	-503
Off-Budget			
Social Security	412	550	138
Postal Service	0	0	0
Consolidated Total	2,419	2,054	-365
Effect of the Proposal			
On-Budget	52	44	-7
Off-Budget			
Social Security	2	9	8
Postal Service	0	0	0
Health alliances[a]	513	513	0
Consolidated Total	566	566	b
Baseline with the Proposal			
On-Budget	2,058	1,548	-510
Off-Budget			
Social Security	414	559	146
Postal Service	0	0	0
Health alliances[a]	513	513	0
Consolidated Total	2,985	2,620	-365

SOURCE: Congressional Budget Office.

a. Receipts of the health alliances would comprise premiums from employers and households and payments by state governments. Federal transactions with the health alliances would be treated as intragovernmental outlays.

b. Less than $500 million.

Conclusion

Two aspects of the Administration's health proposal have made its budgetary treatment particularly contentious. First, the proposal is innovative and complex, and existing budgetary concepts and precedents are less helpful than usual. Second, the proposal does not spell out the requirements for financial reporting by the federal government or the fiscal rules controlling the system of regional and corporate health alliances.

For these reasons, the Congress will want to consider carefully the budgetary presentation and control of the health alliances in its deliberations on the Administration's proposal. If the Congress decided to include the income and outgo of the alliances in the federal government's accounts, it could facilitate their recording and control by requiring them to flow through the Treasury. In any event, the Congress should require the federal government to provide regular financial reports on the health alliances and should bring the alliances under some form of fiscal discipline to ensure that existing budgetary rules are not circumvented.

Chapter Four

Economic Effects of the Proposal

Any fundamental reform of the health care system could have profound effects on the structure of the U.S. economy, and the Administration's proposal is no exception.

Supporters of the Administration's approach argue that it would improve the efficiency of labor markets by reducing insurance-related job lock and the work disincentives Medicaid beneficiaries face. They claim that it would also improve the allocation of resources in the economy by increasing the efficiency of the health sector and strengthen the competitive position of U.S. producers, particularly those with large health burdens for retired workers. Critics of the proposal have argued that it would raise business costs, devastate small enterprises, put some low-wage workers out of their jobs, encourage many workers to leave the labor force, and adversely affect the competitive position of U.S. industry.

This chapter examines the probable impact of the Administration's proposal on important aspects of the economy--business costs, employment, labor markets, and international competitiveness. The complexity of the proposal and of the current U.S. health insurance system makes analyzing these topics especially difficult, and few conclusions can be reached with great precision.

Several conclusions can, however, be drawn with relative confidence. First, the proposal would increase the cash wages of U.S. workers (see Chapter 2). Second, the proposal would without doubt involve a substantial redistribution of costs within the economy, and thus would have important consequences for individual workers and firms. Third, some low-wage workers would lose their jobs because their employers would have to pay for insurance, but this group is likely to be quite small; some others may gain jobs in community-based care for the disabled. Finally, more workers would voluntarily leave employment in response to new incentives created by the proposal, and some workers would enter employment for this reason.

Although the complexity of the proposal makes quantitative inferences imprecise, the Congressional Budget Office estimates that the plan might reduce the number of people in the labor force by one-quarter of a percent to 1 percent, though it would alter the unemployment rate little. Perhaps more important than its effect on the overall labor supply, the proposal is likely to affect the current pattern of where people work.

The Administration's proposal would affect labor markets both by eliminating or reducing existing distortions in these markets and by introducing new ones. Among the distortions that would be reduced are the tendency of the current system to lock people into certain jobs or into welfare because they fear the loss of insurance. It would also end the advantages big firms have in purchasing health insurance. These are important gains. But the proposal would also introduce some distortions of its own: it would encourage early retirement; it would in some cases reduce the attraction of having more than one adult in each family work; it would increase the cost of hiring most minimum-wage workers; and it would encourage the grouping of workers in firms on income lines that may not be efficient.

On balance, the new distortions in the labor markets could outweigh the ones eliminated; should that happen, the productive potential of the econ-

omy would go down, and fewer people would be engaged in market activities that produce income. But the potential loss of market income would overstate any loss to the economy. People who leave work would be doing so from choice and would be able to do things they could not do while working. Although the value of this leisure is certainly not zero, it is not counted in gross domestic product.

A full accounting of the proposal's effect on the economy would have to include its possible impact on the efficiency of the health care system. Few analysts doubt that the current health care system wastes resources (see Box 4-1). The proposal hopes to reduce many of these inefficiencies. The Administration aims to cut administrative costs, foster the growth of health maintenance organizations and other types of plans that might be able to reduce costs below those of fee-for-service providers, and make it easier for consumers to pick more cost-effective health plans. For the most part, this report does not address these questions of the efficiency of the health sector.

Finally, any proposal to reform the current health care system would introduce its own distortions while eliminating others. Evaluation of the Administration's proposal should, therefore, be based on how its costs and benefits compare with those of the alternatives--including current policy.

Box 4-1.
Inefficiencies in the Current Health Care System

For many economists and policymakers, the large proportion of national income going to the health sector--some 14 percent of gross domestic product in 1993--is cause for considerable concern. Behind this concern is a belief that health care markets as currently structured are not efficient and are prone to excessive and unnecessary spending.[1] A successful restructuring of the health care system would correct some of these inefficiencies.

Several factors now hinder the efficient operation of the health sector. First, consumers lack key information about the quality and price of medical services. Treatment costs are difficult to obtain in advance, and comparison shopping can be costly and impractical for sick people. Patients delegate a considerable amount of decisionmaking to their doctors, who are trained to provide the best possible care rather than the most cost-effective care.

Second, the widespread prevalence of health insurance (and other third-party payers) insulates consumers from the full cost of medical care when they are sick. Moreover, health insurance is tax deductible when employers offer it as a fringe benefit, which reduces the incentive for workers to select less expensive policies. Because employers pick up most of the bill, most employees have little idea how much their insurance truly costs.

Because of these shortcomings, health care markets are not truly competitive. Providers generally do not compete as aggressively over price as in other sectors of the economy. Instead, their competition focuses on the nonprice aspects of medical care. For example, hospitals try to attract patients by offering the best and latest medical technologies or the most comfortable surroundings--not the lowest price. At the same time, consumers lack sufficient bargaining clout to offset the tendency of the system to spend too much. The payment system is relatively fragmented, and providers are able to shift costs from large organized payers (like government) to private payers with little countervailing power.

Perhaps most important, technological change is very rapid in the health care sector, but market constraints that might ensure that new technologies are used in cost-efficient ways may not operate effectively. As long as health insurance pays for new technologies, the private sector is encouraged to develop any innovation, regardless of cost, that is likely to improve the quality of care. Other countries strictly control the supply of new technology to the health sector. But there is no effective mechanism in the current U.S. system--neither a market nor a government regulatory plan--to ensure that the costs of new technologies will be kept in line with their benefits.

1. Congressional Budget Office, *Economic Implications of Rising Health Care Costs* (October 1992).

Key Aspects of the Proposal That Would Affect the Economy

The Administration's proposal contains literally hundreds of provisions that would make fundamental changes in the delivery and financing of the nation's health care. Nevertheless, the most important economic effects can be traced to just a few features.

Universal Coverage

The Administration's proposal would entitle all citizens and certain other people residing in the United States to a standard package of health insurance benefits. Unlike the current system, benefits would no longer depend on whether or where a person worked.

Community Rating

Insurance premiums could not vary with age or health status. The new system would therefore incorporate the cost and spread the burden for people who present the greatest health risks.

Controls on Health Insurance Premiums

The Administration's proposal would limit the growth of health spending by fostering competition and capping premium costs.

Employers' Responsibilities

Employers would be required to pay a significant share of the health insurance premiums for virtually all of their employees. Health benefits would no longer be a flexible component of employee compensation but rather would become an inflexible levy on employing workers.

Subsidies to Employers

A firm in a regional alliance would not have to pay more than 7.9 percent of its wage and salary payroll for its share of health insurance; instead, the government would pay for premiums for the standard insurance package above that amount. Lower limits would apply to firms with 75 or fewer employees and low average wages.

Subsidies to Early Retirees

The government would subsidize the average premium for early retirees. This would reduce the incentive to continue to work, thus changing the size of the work force.

The Effects on Health Spending by Business

The Administration's proposal would maintain the central role of employers in financing health care in the United States, but would significantly alter the distribution of costs among businesses and workers. After 1996, the proposal would most likely reduce the total spending of business on health care. Of course, businesses would be asked to pay directly for insurance for those workers who are currently uninsured, and the Administration's proposed insurance package is more generous than many firms currently offer. Employers who formed corporate alliances would pay an additional 1 percent payroll tax. But although these factors would tend to increase businesses' costs, they would be more than offset after 1996 by the limits on premium growth and the subsidies from the government.

Big Cost Reductions Overall for Business

When all these factors are taken into account, the total cost that all businesses together would pay for health insurance for active workers would be about $20 billion less in the year 2000 if the proposal were implemented than if the current system were

to continue unchanged.[1] The estimated reduction in the cost for active workers from the proposal would be even larger in subsequent years, reaching slightly above $90 billion in 2004.

Businesses would also benefit from a large reduction in costs for workers taking early retirement. This reduction would amount to more than $15 billion in the year 2004, and more thereafter.

Diverse Effects Among Individual Firms

Even though the plan would quite dramatically reduce the overall cost of health insurance for business, it would have widely differing effects on individual firms and industries, in some cases causing costs to rise and in others reducing them. Three factors account for most of the diversity.

Requiring All Employers to Pay. The requirement on all employers to contribute would raise spending by firms that do not currently offer insurance--or that offer a less generous insurance package--to their workers. These firms are disproportionately small--in 1989, over 94 percent of firms with 25 or more employees offered health insurance, but only 39 percent of firms with fewer than 25 employees did so.[2]

Community Rating. Currently, the cost of health insurance varies tremendously among firms, depending on the size of the firm and the age and health status of its workers. Under the Administration's proposal, insurance premiums would be community rated, which would greatly reduce this variation in health spending. For example, community rating would increase the costs of firms that employ younger and healthier workers and those in low-risk jobs, and decrease the costs of firms employing older and sicker workers and those in risky jobs. Further, community rating would benefit smaller firms that typically pay much higher premiums than larger firms. This leveling of costs could benefit all small businesses--not just those that provide insurance today. With access to more affordable insurance, small businesses would be better able to attract workers who now demand health insurance as a condition of employment.

Estimating the effect of these two factors--community rating and requiring all firms to pay--on various industries is beyond the scope of this study, but estimates prepared by Henry Aaron and Barry Bosworth at the Brookings Institution provide a rough guide (see Table 4-1).[3] These calculations do not capture some key aspects of the Administration's proposal. For example, they do not include the effects of subsidies to firms, nor do they allow for variations in the premiums among regional alliances that would occur under the proposal. Most important, they do not include the cost savings that controls on premiums would bring about.

Nevertheless, Aaron and Bosworth's estimates suggest that community rating and requiring firms to pay would cause an enormous redistribution of resources among workers in different industries. The redistribution would be even greater among subsectors of industries and individual firms not shown in the table. For example, Aaron and Bosworth's detailed estimates suggest that these two factors would decrease the annual cost of health insurance by almost $6,000 per worker in the coal mining industry--but increase it by $1,300 in the retail sector.

These redistributions are not unique to the Administration's proposal. Most proposals to reform the nation's health care system involve some community rating, and some also require all employers to pay. Those proposals would also redistribute large amounts of resources among firms and workers.

Subsidies to Firms. The subsidies to employers in the Administration's proposal would also affect how

1. The Administration also predicts that the plan would reduce business spending, compared with current policy, by similar amounts. By contrast, another analysis, by the consulting firm Lewin-VHI, estimated that the proposal would increase business spending by about $16 billion in 2000. See Lewin-VHI, *The Financial Impact of the Health Security Act* (Fairfax, Va.: Lewin-VHI, December 1993).

2. Congressional Budget Office, *Rising Health Care Costs: Causes, Implications, and Strategies* (April 1991).

3. The premiums under community rating in Table 4-1 are not identical among industries because each industry pays a different amount for retirees.

Table 4-1.
Effects of Community Rating and Requiring Firms to Pay on the Health Insurance Costs of Private Employers, by Industry, 1992

Industry	Employer Contributions for Health Insurance				
	Current Costs		Costs with Community Rating and All Firms Paying (Dollars per worker)[a, b]	Difference	
	Dollars per Worker[a]	Percentage of Wages		Dollars per Worker[a, b]	Percentage of Wages
Agriculture, Forestries, and Fishing	394	2.5	2,041	1,647	10.3
Mining	4,776	11.4	3,048	-1,728	-4.1
Construction	1,572	5.4	2,373	800	2.7
Manufacturing	3,466	10.7	2,416	-1,050	-3.2
Durable goods	3,801	11.2	2,452	-1,349	-4.0
Nondurable goods	3,017	10.0	2,367	-649	-2.2
Transportation	2,221	7.1	2,412	191	0.6
Communications	6,572	15.6	3,070	-3,502	-8.3
Electric, Gas, and Sanitary Services	4,871	11.3	2,804	-2,067	-4.8
Wholesale Trade	2,426	7.1	2,177	-249	-0.7
Retail Trade	788	4.5	2,090	1,303	7.5
Finance, Insurance, and Real Estate	2,123	5.9	2,190	67	0.2
Services	1,480	5.5	2,177	697	2.6
Private Households	0	0	2,041	2,041	16.5
All Industries	2,017	7.2	2,253	236	0.8

SOURCE: Congressional Budget Office based on Henry Aaron and Barry Bosworth, "Economic Issues in the Reform of Health Care Financing," *Brookings Papers on Economic Activity* (forthcoming).

a. Based on full-time-equivalent workers.

b. Includes a 13 percent increase in average costs to cover uninsured workers and assumes uniform costs for nonretirees (community rating). Does not reflect the effects of the cost controls in the Administration's proposal. Retiree health costs account for the variation among industries.

insurance costs are distributed among companies. Other things being equal, firms with low wages would be more likely to be subsidized. Many small firms would also face lower caps (and receive larger subsidies per person) than large firms. Finally, firms located in regions of the country with high medical costs might receive higher subsidies because their premiums would be higher. Yet some regions with high medical costs also pay higher wages, so it is difficult to infer the regional impact of the Administration's proposal without more information about how the boundaries of the alliances would be drawn.

Who Bears the Burden of Health Spending by Business?

Although businesses initially pay a large portion of the bill for health insurance, people ultimately bear these costs. Workers may pay them in the form of lower wages, consumers in the form of higher prices, and shareholders through lower returns on their investments. But for the most part, the nation's workers shoulder the cost of employers' premiums for health insurance. Thus, the signifi-

cant savings that the Administration's proposal would produce compared with current policy would be largely passed on to workers in the form of higher wages.

Why Workers Pay for Health Costs

The primary reason that workers as a group bear the cost of employers' health premiums--and would realize the savings under the Administration's proposal--is that the supply of labor is relatively insensitive to changes in take-home wages. Recent empirical studies suggest that the total hours supplied by U.S. workers would decline only 0.1 percent to 0.2 percent for each 1 percent reduction in their take-home wage.[4] Because most workers continue to work even if their take-home pay declines, businesses have little trouble shifting most of the cost of health insurance to workers' real wages. Similarly, workers gain the lion's share of any reductions in employers' health costs.

Two recent studies of mandated benefits mirror this view.[5] In one study, firms shifted 85 percent of the cost of mandated "workers' compensation" accident insurance to workers in the form of lower real wages; another study found that virtually all of the cost of federal and state mandates for childbirth coverage was passed into lower real wages.[6]

Of course, because labor supply is not completely insensitive to changes in wage rates, shareholders would bear some of the changes in health insurance costs in the short run. But they would probably bear virtually none of these costs in the long run. The United States operates in a world economy and, if businesses attempted to shift such costs to capital, shareholders would move their investments to other countries that offered them higher returns.

Shareholders, however, would benefit from reductions in the cost of retirees' health insurance. The Administration's proposal would reduce costs for companies that currently have large retiree health obligations. The government would take over a significant portion of companies' responsibility for health insurance for early retirees and drugs for older retirees. The companies' workers and their unions would probably fight for a portion of that windfall, and the gain would therefore be split among shareholders, workers, and retirees.

How Savings Might Be Distributed

Although the wages of workers (as a group) would increase to reflect reductions in the cost of health insurance for current employees under the Administration's proposal, the benefits would not be spread evenly among individual workers for at least two reasons.[7] First, by evening out the costs of insurance, community rating would raise the costs of employing some individuals relative to current policy, but reduce them for others. Second, individual firms could respond differently to these changes in costs. Some might change the nominal wages of their workers; others might adjust their prices.

For the economy as a whole, lower prices for some products would largely be offset by higher prices for others.[8] But because individuals purchase

4. Congressional Budget Office, "Taxes and Labor Supply," CBO Memorandum (forthcoming); Mark Killingsworth, *Labor Supply* (Cambridge, England: Cambridge University Press, 1983); and James Heckman, "What Has Been Learned About Labor Supply in the Past Twenty Years?" *American Economic Review*, vol. 83, no. 2 (May 1993), pp. 116-121.

5. Jonathan Gruber and Alan B. Krueger, "The Incidence of Mandated Employer-Provided Insurance: Lessons from Workers' Compensation Insurance," *Tax Policy and the Economy* (1991); and Jonathan Gruber, "The Incidence of Mandated Maternity Benefits," *American Economic Review* (forthcoming).

6. Lawrence H. Summers, "Some Simple Economics of Mandated Benefits," *American Economic Review*, vol. 79, no. 2 (May 1989), pp. 177-183. The Administration's proposal would probably have a smaller effect on real wages--and a larger effect on employment--than implied by these studies. Unlike a pure employer mandate, the Administration's proposal would entitle everyone to insurance whether they worked or not and would finance the proposal through a compulsory payment.

7. Henry Aaron and Barry Bosworth, "Economic Issues in the Reform of Health Care Financing," *Brookings Papers on Economic Activity* (forthcoming).

8. Because the Administration's proposal would cause the labor force and output of the economy to fall slightly, the overall price level could rise somewhat in the long run compared with current policy. The effect on output and prices would be somewhat larger in the short run because firms that would face cost increases might not be able to reduce the nominal wages of their workers. Over time, these firm would be able to bring nominal wages back in line by simply not compensating their workers for general inflation. Finally, this discussion excludes any possible actions by the Federal Reserve.

different bundles of goods and services, individual workers and consumers could experience significantly different effects.

In some respects, the Administration's proposal would reduce the likelihood that firms with cost increases would raise prices. Community rating virtually assures that competing firms would face very different changes in their insurance costs. Unless most competitors in an industry faced similar changes in their costs, it would be difficult for any single firm to raise its prices much without losing market share.

What Would Happen to the Labor Force and Unemployment?

The Administration's health proposal would sharply change the terms of the employment bargain for many workers, reducing some distortions implicit in the current system and imposing others. Overall, the proposal would probably impose greater employment-related distortions than it removed. The supply of labor would probably fall slightly, somewhat reducing the productive capacity of the economy, but unemployment would be little changed.

In summary, the proposal would:

- Encourage workers nearing retirement age to retire early, by subsidizing their health insurance in early retirement;
- Reduce the value of working for people who receive insurance through their spouses and currently work at firms without insurance;
- Reduce the current incentive for recipients of Aid to Families with Dependent Children to remain on the welfare rolls and out of work in order to maintain their Medicaid benefits; and
- Raise the cost of hiring some adult workers who earn close to the minimum wage, thus slightly reducing their employment.

These direct effects of the plan--which would result on balance in a reduction in labor supply--would in turn produce a partially offsetting change. Competition among employers for the reduced labor supply would slightly raise real wage rates. But the effect of a rise in wages would not completely offset the direct effects of the proposal.

Increase Early Retirement

Three features of the Administration's proposal would create significant incentives for workers between 55 and 64 years old to take early retirement. First, because the proposal would guarantee universal coverage and premiums would not vary with health or employment status, early retirees need not fear becoming uninsured. Thus, older people would no longer have to work simply because they need access to affordable health insurance. Most analysts would regard this as a clear improvement over the current situation, even though it would reduce the supply of labor.

Second, the proposal goes further and would subsidize health insurance for retired people between the ages of 55 and 64. However, people in this age group who worked full-time (or whose spouses worked full time) would not receive this benefit. The subsidies would sharply reduce costs for those firms that currently offer health insurance to early retirees, and might induce them to sweeten the other components of their retirement package.[9] Aside from any consideration of fairness, this provision would clearly reduce the incentive to work.

Finally, community rating among age groups means that early retirees would face premiums that, even before considering subsidies, would be no higher than those paid by younger people. Because older people currently pay much higher premiums than young people, community rating would significantly reduce the savings that workers would need to accumulate for retirement, and some might find they could retire earlier.

9. Roughly half of the savings for these firms in 1998 through 2000 would be recaptured by the government. The proposal includes no provisions to recapture savings from firms after 2000.

The Administration estimates that the health proposal could increase the number of retired workers ages 55 to 64 by 350,000 to 600,000. CBO's analysis also suggests effects in about this range, although probably closer to the upper end or slightly above. These estimates are roughly consistent with the results of a recent study by Brigitte Madrian of Harvard University.[10]

Impose an Implicit Levy on Work

The Administration's proposal would bring about a major change in the nature of health care costs: for many workers, the cost would operate like a new levy on work. However, most people's decisions about whether to work or not are not particularly sensitive to changes in their take-home wages or salaries. Consequently, the effect of the proposal on the total labor force would be relatively small and limited largely to second workers in households in which one person already works.

The proposal would create an implicit levy on work because it would make health coverage universal without charging many nonworkers for the full cost of their insurance. In other words, coverage under the proposal would not depend on whether one worked and paid the premium or stayed at home and, often, paid much less. The premium would simply reduce take-home pay without, from the point of view of the individual worker, buying anything.

By contrast, under the current system, employers provide health insurance to many of their workers as part of an implicit or explicit bargain, which ensures that the cost of health insurance does not stray too far from what most workers feel it is worth.[11] Thus, health insurance is a component of compensation that substitutes for cash wages and, therefore, has little effect on an individual's decisions about whether and how much to work.

That bargain is not perfect for several reasons. Most important, some married people who work in firms that offer health insurance are or could be covered under a spouse's policy.[12] For these people, the availability of health insurance at work is worth little. But many of these workers are not compensated in other ways for the insurance they do not use.[13] This situation distorts decisions about whether and where to work; it also partly explains why some married women work in firms that do not offer insurance.[14]

The Administration's proposal would extend this distorting effect on decisions about work to everyone. However, the proposal would also reduce premiums for currently insured workers because all workers would have to pay for insurance and because administrative costs are apt to be less--particularly for small firms. On balance, the proposal would probably impose a somewhat larger distortion on decisions about work than exists under the current system.

---

10. Brigitte Madrian, "Labor Market Effects of Employment-Based Health Insurance" (Ph.D dissertation, Massachusetts Institute of Technology, Cambridge, 1993), Chapter 2. Other studies suggest much larger responses. See Jonathan Gruber and Brigitte Madrian, "Health Insurance Availability and the Retirement Decision," Working Paper 4469 (National Bureau of Economic Research, Cambridge, Mass., September 1993); and Michael Hurd and Kathleen McGarry, "The Relationship Between Job Characteristics and Retirement," Working Paper 4558 (National Bureau of Economic Research, Cambridge, Mass., December 1993). Although one study found that retirees' health insurance had little effect on retirement, those results cannot be applied to the Administration's proposal; see Alan Gustman and Thomas Steinmeier, "Employer-Provided Health Insurance and Retirement Behavior," Working Paper 4307 (National Bureau of Economic Research, Cambridge, Mass., March 1993).

11. Employer-paid health insurance premiums are not included in a worker's taxable income for either income tax or payroll tax calculations. Thus, health insurance benefits that have a lower value than a given amount of cash wages before taxes may have a higher value after taxes are accounted for. The statement in the text refers to workers' after-tax valuation of insurance benefits.

12. Another reason that the employment bargain is not perfect is that some health care is available to people without insurance. Workers who pay for insurance effectively subsidize these "free riders."

13. At the few firms that offer "cafeteria" plans, workers can substitute wages or other benefits for unneeded health insurance. Similar adjustments may also occur at other firms, but it is hard to know whether this phenomenon is widespread. If such adjustments are widespread, then fewer people would be in the category described in the text.

14. Patricia M. Danzon, "Mandated Employment-Based Health Insurance: Incidence and Efficiency Effects," Working Paper 60 (Center for the Study of the Economy and the State, University of Chicago Chicago, Ill., April 1990).

Would everyone recognize that the proposal imposed a distortion? Perhaps not. Some workers may not recognize the implicit trade-off in the current system between employer-paid health insurance benefits and cash wages.[15] For these workers, the Administration's proposal would not appear to represent such a fundamental change in the employment bargain.

Although the proposal would reduce the incentive to work for many workers, the vast majority would nevertheless remain in the labor market because they need wage and salary income to support themselves or their families. But some people---especially those whose spouse is employed--have more flexibility in their decision to work. These so-called "secondary" workers are more responsive to changes in work incentives because they can rely on their spouse's income. The Administration's proposal would thus reduce the participation of secondary workers in the labor force.

Encourage Medicaid Beneficiaries to Enter the Labor Force

The Administration's proposal would reduce the current incentive for AFDC beneficiaries to remain on welfare. Under current rules, when a welfare beneficiary goes to work and earns income above certain thresholds, the beneficiary may lose both eligibility for cash assistance and Medicaid coverage.[16] Because such workers may not find employment at a firm that offers insurance, they may lose access to affordable health benefits if they work.

The Administration's proposal, by contrast, would make coverage universal. Thus, welfare beneficiaries would not risk losing coverage if they worked. Note, however, that these workers would not receive free insurance when they went to work. Like all other workers, they would ultimately pay for the employers' share of insurance through lower cash wages. Thus, the net incentive for welfare recipients to work would be less than it may at first appear.

Still, the proposal would subsidize health insurance at many firms, and workers at such firms would have to pay, at most, 7.9 percent of their wages for insurance (and less if the firm is small and has a predominantly low-wage work force). Premiums at unsubsidized firms could, however, absorb a substantial fraction of these workers' wages; few welfare recipients would probably seek jobs in the unsubsidized sector.

These workers could also receive some subsidies for the family share. If the worker continued to receive AFDC assistance, he or she would pay nothing. Workers who were no longer enrolled in AFDC would also receive subsidies, although they would be required to pay a portion of the family share.[17] These subsidies would phase out gradually as the worker's family income rose, reaching zero when income was 150 percent of the poverty level. The phaseout of the subsidy would impose an implicit levy on additional hours of work.

Empirical studies show that Medicaid has reduced participation in the labor force.[18] But estimating the effects of the Administration's proposal is difficult because the available studies cannot easily be adapted to it. Nevertheless, the literature suggests that the proposal would noticeably increase participation of AFDC recipients in the labor force.

---

15. Aaron and Bosworth, "Economic Issues in the Reform of Health Care Financing."

16. Different thresholds apply for AFDC eligibility and Medicaid eligibility. Medicaid coverage may be maintained for a transition period of up to 12 months after starting work.

17. When a family no longer received AFDC, the family would also lose the subsidy for copayments and supplementary services for the parent. Supplementary services for children would be continued as at present.

18. Aaron Yelowitz, "The Medicaid Notch, Labor Supply, and Welfare Participation: Evidence from Eligibility Expansions" (Massachusetts Institute of Technology, Cambridge, September 1993); Sandra Decker, "The Effect of Medicaid on Participation in the AFDC Program: Evidence from the Initial Introduction of Medicaid,"(New York University, New York, N.Y., 1993); Robert Moffitt and Barbara Wolfe, "The Effect of the Medicaid Program on Welfare Participation and Labor Supply," *The Review of Economics and Statistics*, vol. 74, no. 4 (November 1992), pp. 615-626; Anne E. Winkler, "The Incentive Effects of Medicaid on Women's Labor Supply," *The Journal of Human Resources*, vol. 26, no. 2 (Spring 1991), pp. 308-337; Rebecca M. Blank, "The Effect of Medical Need and Medicaid on AFDC Participation," *The Journal of Human Resources*, vol. 24, no. 1 (Winter 1989), pp. 54-87.

Redirect Employment of Low-Wage Workers

The Administration's health proposal would affect employment of low-wage workers in a variety of ways. It would raise labor costs at uninsured firms and would reduce the employment of some of their low-wage, adult workers. But it would also reduce labor costs at insured firms, which could tempt some of them to employ more workers. At the same time, the proposal would increase employment of workers who provide services for the disabled and could induce a shift toward teen and student employment. On balance, the Administration's proposal would probably have only a small effect on low-wage employment.

Workers at Firms Without Insurance. The Administration's proposal would reduce the employment of adult workers who are currently uninsured and whose wages are close to the federally regulated minimum wage. The requirement that firms pay for insurance would raise the cost of employing these workers, but because of the minimum wage rules, employers would not be able to pass the increased cost fully back to the workers by reducing their cash wages. Thus, firms that could not absorb these costs in profits or could not raise their prices might resort to layoffs.

The amount of the cost increase for minimum-wage workers would vary significantly from firm to firm.[19] Firms subject to the premium caps, and thus subsidized, would experience increases amounting to between 15 cents and 34 cents per hour--probably not enough to have a serious impact on employment. The increases at unsubsidized firms would be substantially larger, amounting to about $1 per hour (or close to 25 percent) for full-time workers choosing individual policies in 1998 and almost $2 per hour (nearly 45 percent) for workers choosing family policies.[20]

Some firms would respond to this cost increase by raising their prices; others might pass the increase on to other workers or shareholders. Some firms would reduce employment, but the effect would probably be relatively small. Past empirical studies suggest that changes in the minimum wage affect employment only modestly.[21] Moreover, the numbers of workers earning the minimum wage will decline over time as market wages rise with general inflation.

Workers at Insured Firms. Not all low-wage workers would face increases in health costs. Although most firms that employ minimum-wage workers do not offer insurance to those workers, some firms do, and these firms would most likely see their costs go down. A firm that is subject to the payroll cap would have to pay no more than $700 to cover the insurance cost of a full-time minimum-wage worker--considerably less if the firm is small and employs mostly low-wage workers--and this amount would be well below the cost of most current health plans. Because small, unsubsidized firms would benefit from community rating and from a reduction in administrative costs, many of them would also see their costs go down. In firms where costs could fall, employment of low-wage workers could rise, though again not by much.

Teenagers and Students. The Administration's proposal does not require employers to pay for employees who are dependents and who are either under age 18 or full-time students under age 24. Thus, the proposal would reduce the cost of hiring these workers relative to adult minimum-wage workers. This provision could induce a shift toward employment of teens and students and away from adult nonstudent workers, although it is difficult to estimate the magnitude of this effect.

---

19. For information on insurance coverage of low-wage workers, see Congressional Budget Office, "In Pursuit of Higher Wages and Employment-Based Health Insurance," CBO Memorandum (February 1993).

20. Using CBO's premium estimates for 1998 and assuming a 37-hour week for 52 weeks.

21. Allison Wellington, "Effects of the Minimum Wage on the Employment Status of Youths: An Update," *The Journal of Human Resources*, vol. 26, no. 1 (Winter 1991), pp. 27-46; "New Minimum Wage Research: A Symposium," *Industrial and Labor Relations Review*, vol. 46, no. 1 (October 1992), pp. 3-88; David Card, Lawrence Katz, and Alan Krueger, "An Evaluation of Recent Evidence on the Employment Effects of Minimum and Subminimum Wages," Working Paper 4528 (National Bureau of Economic Research, Cambridge, Mass., November 1993); Janet Currie and Bruce Fallick, "A Note on the New Minimum Wage Research," Working Paper 4348 (National Bureau of Economic Research, Cambridge, Mass., April 1993).

Personal Care Workers. The Administration's proposal would also directly increase employment in one low-wage area--personal care and other in-home workers. Although most aspects of it aim to reduce spending on health care, the proposal would substantially increase funds for home- and community-based care, which would expand the employment of both higher-paid and lower-paid workers in this sector.

The proposal also could bring into the labor force statistics--and into the gross domestic product accounts--an unknown number of family members who currently provide uncompensated care for the disabled. Current rules do not permit these people to be paid with government money, and thus they are not counted in the labor force or in GDP. The proposal would allow these people to be paid and thus bring them into both sets of statistics. The recognition of the work effort of these family members would be important to the disabled and their families. From the national point of view, however, this would be largely a statistical change and would not alter the true amount of economic activity.

What Would Happen to the Structure of the Labor Market?

The Administration's health proposal would create incentives for reorganizing the structure of production. To start, these incentives would alter the number of hours that people work, and particularly the decisions of firms to hire full-time or part-time workers. The proposal would also allow workers to switch jobs without losing insurance, but it might induce some reallocation of workers among firms in an effort to receive greater government subsidies.

Hours of Work

The Administration's proposal would affect not only the number of workers in the economy but also the number of hours that they work. Specifically, the proposal would encourage a reduction in hours for full-time workers in subsidized firms but an increase in hours for full-time workers at some unsubsidized firms. The proposal would also encourage a reduction in the hours of most part-time workers.

Subsidized Firms. Under the proposal, subsidized firms would pay an implicit levy on the wages earned by their employees from each additional hour of work. At many subsidized firms, this levy would equal 7.9 percent; at small firms with low average wages, it could be as low as 3.5 percent. The levy would apply to full-time and part-time workers in the same way, and would be passed back to workers in the form of lower wages. This provision would create an incentive for both full-time and part-time workers at subsidized firms to reduce their hours of work.

Unsubsidized Firms. At unsubsidized firms, the proposal would impose no added cost on the wages earned from additional hours of work by people already working more than 30 hours per week. Thus, at unsubsidized firms that offer insurance today, the proposal would have no appreciable effect on hours worked by full-time employees. At unsubsidized firms that do not offer insurance today, however, there would be a new fixed cost of hiring additional full-time workers, which would cause firms to use more overtime by their existing workers.

Part-time employees at unsubsidized firms would face an implicit levy on hours because the proposal prorates premiums for these workers. For an additional hour of work by employees working between 10 and 30 hours per week, unsubsidized firms would generally have to pay one-thirtieth of the basic employer premium. This amount could be large relative to the wages of some low-wage workers.[22]

Workers with Very Short Hours. The proposal might cause some firms to increase their use of employees who work fewer than 40 hours per month

22. The proposal would impose particularly large costs on part-time workers with jobs in more than one unsubsidized firm. For example, the combined employer premiums for a worker who has two 20-hour-a-week jobs are 33 percent more than the employer premium for a 40-hour worker with just one job. This situation does not exist for workers in subsidized firms because they pay a fixed percentage of their salary regardless of their hours of work.

because neither subsidized nor unsubsidized firms would be required to pay premiums for these workers. The number of such workers would probably be small, however, and they would primarily be workers with low training and transportation costs.

Effect on "Job Lock"

Some of the proposal's provisions would reduce problems created by the current employment-based system of health insurance. Under the current system, people may be reluctant to leave the safety of a large corporation to work in a small company or start a small business because they fear losing their health insurance. Because the proposal would establish universal coverage and prohibit restrictions based on preexisting health conditions, this fear would be lifted. Workers could choose jobs that gave them the most satisfaction and at which they had the highest productivity, thus improving economic efficiency.

The quantitative importance of job lock is unclear, however. Public opinion surveys suggest that 10 percent to 30 percent of people feel locked into their current jobs because of their fear of losing health insurance.[23] But statistical studies of the extent to which this fear actually reduces job mobility have reached mixed conclusions.[24] Overall, the weight of evidence suggests that job lock probably hinders the operation of the labor market to some degree, but the magnitude of the effect cannot be reliably estimated.

Reallocation of Workers Among Firms

The current system of employment-based health insurance influences the allocation of workers among firms. People who receive insurance coverage through their spouses--or low-wage workers who place a low value on health insurance relative to their other needs--have an incentive to work at firms that do not offer health insurance but pay higher wages instead. At the same time, higher-wage workers who do not have alternative access to insurance typically work at firms that provide insurance coverage.

The Administration's proposal would eliminate the allocation of labor based on workers' demand for insurance. But the proposal would substitute an incentive for reallocating labor (so-called "sorting") based on wages: to take advantage of the subsidies to firms available under the proposal, low-wage workers would migrate to firms with low average wages, and high-wage workers would eventually move to firms with high average wages. As with many other issues discussed in this chapter, the precise effects of the proposal would vary among workers and firms (see Box 4-2).

This sorting would occur because the subsidies are based on the characteristics of firms; subsidies based purely on individual or family characteristics would not have this effect, nor would a payroll tax levied at uniform rates on all firms. Therefore, these incentives for sorting are somewhat particular to the financing mechanism in the Administration's proposal. Of course, alternative schemes for financing universal coverage could also introduce new distortions, though the precise effects would depend on the details of any alternative.[25]

The Incentive for Sorting. A simple example illustrates how workers could benefit by moving between firms that were subsidized and firms that were unsubsidized. If an unsubsidized firm hired an additional single, childless worker at an annual salary of $10,000, its payments to the regional alliance

23. Erik Eckholm, "Health Benefits Found to Deter Switches in Jobs," *The New York Times*, September 26, 1991, p. 1; Christopher Conte, "Labor Letter," *The Wall Street Journal*, June 15, 1993, p. A1.

24. Douglas Holtz-Eakin, "Job-Lock: An Impediment to Labor Mobility?" *Jerome Levy Economics Institute of Bard College Public Policy Brief*, vol. 10 (1993); Brigitte Madrian, "Employment-Based Health Insurance and Job Mobility: Is There Evidence of Job-Lock?" Working Paper 4476 (National Bureau of Economic Research, Cambridge, Mass., September 1993); Jonathan Gruber and Brigitte Madrian, "Limited Insurance Portability and Job Mobility: The Effects of Public Policy on Job-Lock," Working Paper 4479 (National Bureau of Economic Research, Cambridge, Mass., September 1993).

25. Louise Sheiner, "Mandates with Subsidies: Efficiency and Distributional Consequences" (Federal Reserve Board, January 1994).

would rise by $2,031 (CBO's estimate of the employer share of the premium in 1998). By contrast, a subsidized firm would have to pay only $790 to the alliance if it hired the worker, since subsidized firms would pay only 7.9 percent of payroll for insurance. If the worker had the same value to both firms, the subsidized firm could pay a substantially higher annual salary--as much as $1,241 more--than the unsubsidized firm. This is a rather large difference; it would increase the worker's salary by more than 12 percent.

The incentive would work in the opposite direction for higher-wage workers, though it might take a long time to affect where people work. A single, childless worker earning an annual salary of $40,000 would have to give up $3,160 of his or her salary for insurance in the subsidized firm (7.9 percent of $40,000), and thus could save up to $1,129 each year by moving to an unsubsidized firm, where the premium would not be based on salary.

The size of the sorting incentive would vary among both workers and firms. In the example above, the incentive would obviously be amplified for workers with annual salaries above $40,000 or below $10,000. In addition, small firms with very low average wages would have capped rates as low as 3.5 percent, which would further boost the incentive for low-wage workers to work at these firms. Last, the size of the incentive would depend on the family status of the worker--workers with children would face higher premiums at unsubsidized firms than workers without children. At subsidized firms, the employer share of the premiums would simply be 7.9 percent of the worker's wages or salary whether the worker was a single adult, or part of a couple or a family with children.

Forms of Sorting. Sorting could take several forms, some involving actions of workers, some involving actions of firms, and some involving actions of both parties. For example, new workers in the labor force could choose jobs with certain firms rather than others. Or existing workers could quit and move to different firms.

Firms could "outsource"--that is, lay off employees and contract with other companies for the

Box 4-2.
Sorting of Workers in the Administration's Proposal

The incentive for sorting under the Administration's proposal would vary among workers, but most workers can be classified into one of three groups for this purpose.

First, the Administration's proposal would provide a substantial new incentive for sorting among workers who place a significant value on insurance and whose wages are flexible in the long run. Because these workers' wages adjust to reflect the cost of their employment-based health insurance, these workers face no incentive under the current system to leave their jobs. But under the proposed system, those who have low wages would seek jobs at subsidized firms, while those with high wages would seek out unsubsidized firms. This group is rather large--it includes all heads of households except those with very low incomes.

The second group of workers are those who place a high value on insurance but whose wages are not flexible even in the long run. Because the productivity of these workers may not be high enough to cover the minimum wage plus the cost of health insurance, they tend to find work at firms that do not offer insurance. If the current system is maintained, more of these workers would be forced into uninsured firms as the cost of health insurance rose. By contrast, the subsidies in the Administration's proposal would reduce this incentive for sorting. This group is not large and consists primarily of minimum-wage and near-minimum-wage workers.

The last group consists of workers who place a low value on insurance. The current system encourages these workers to work at firms without insurance, and again this incentive increases as health insurance costs rise. The Administration's proposal would eliminate this incentive for sorting because every firm would have to offer insurance. But the proposal would substitute an incentive for high-wage workers in this group to move to firms with high average wages and low-wage workers to move to firms with low average wages. This group is fairly sizable because it includes most secondary workers and some younger and poorer primary workers as well.

same services. For example, a firm with high average wages, which would be unsubsidized under the proposal, could give up its company's cleaning help and hire an outside cleaning service instead. Alternatively, firms could divide themselves into subsidiaries with low and high average wages. For example, a manufacturing plant could spin off its research and development lab.

Although the proposal contains legal restrictions on some of this sorting, they would not be totally successful.[26] The proposal would increase the Internal Revenue Service's authority over the classification of employees and independent contractors, but reclassification of these workers is just one of several ways in which firms could respond to the proposal. Moreover, any simple regulation is unlikely to prevent the creation of new firms that could use the subsidies to their competitive advantage against existing, regulated firms.

Sorting Would Raise the Cost of Federal Subsidies to Firms. When sorting occurs, workers would be reallocated among firms in a way that reduced the private cost of their health insurance. But this reduction in private cost would be exactly offset by an increase in government spending.

Of course, it is difficult to determine exactly how much sorting would occur under the Administration's proposal. Some restructuring along salary lines may be occurring anyway.[27] There are no empirical estimates indicating the sensitivity of the allocation of workers to incentives of this type. But the incentive for sorting under the proposal would be fairly large for many people. CBO estimates that in 1998 almost 8 million low-wage workers could receive salary increases of 10 percent or more by moving from unsubsidized to subsidized firms. And the average increase in salary for workers earning less than $20,000 who migrated from unsubsidized to subsidized firms would be over 15 percent.

CBO assumes that 20 percent of the workers would eventually respond to a potential 10 percent increase in their after-tax salaries; workers facing larger or smaller incentives would have proportionally larger or smaller responses. This sorting would not occur immediately, however. CBO assumes that it would take 10 years after full implementation of the proposal for sorting to reach its full extent and estimates that sorting could increase the cost of subsidies to firms by some $12 billion (or 14 percent) in 2004, an amount incorporated in the cost estimate in Chapter 2.

Sorting Would Alter the Effects of the Proposal on Employment. As discussed in an earlier section, the requirement that firms pay for health insurance would reduce the employment of low-wage workers. The sorting of these workers among firms would mute this effect, however. Low-wage workers who are currently uninsured would be induced to leave unsubsidized firms where they would face large implicit increases in the minimum wage and move to subsidized firms where the implicit minimum wage increase would be relatively modest. This migration would limit the number of displaced workers.

At the same time, sorting could produce some temporary loss of employment, if workers lost their jobs and were forced to look for new ones. Ironically, the harder the government tried to prevent sorting in the form of simple legal reorganizations, the more it would encourage firms to sort workers by laying them off. Of course, employers would be trying to contract with other companies to provide the same services, so overall demand in the economy for these workers' skills might be unaffected. But this possibility does not mean that the same workers would find jobs immediately, and those that could not would experience some short-run unemployment.

---

26. Eugene Steuerle, "The Proposed Segregation of the Labor Market by Economic Class," *Tax Notes*, vol. 61, no. 5 (November 1, 1993), pp. 621-622.

27. Because some sorting would occur without any policy change, the subsidies to firms would grow over time even if the Administration's proposal induces no additional sorting. In other words, what matters for the cost of subsidies is the total amount of income-based sorting, not just the amount created by the proposal. See Katharine G. Abraham, "Restructuring the Employment Relationship: The Growth of Market-Mediated Work Arrangements," in Katharine G. Abraham and Robert B. McKersie, eds., *New Developments in the Labor Market* (Cambridge, Mass.: MIT Press, 1990); Katharine G. Abraham and Susan K. Taylor, "Firms' Use of Outside Contractors: Theory and Evidence," Working Paper 4468 (National Bureau of Economic Research, Cambridge, Mass., September 1993); and Steve J. Davis and John Haltiwanger, "Wage Dispersion Between and Within U.S. Manufacturing Plants, 1963-1986," Working Paper 3722 (National Bureau of Economic Research, Cambridge, Mass., March 1991).

Sorting Could Reduce the Efficiency of the Labor Market. A competitive market economy allocates workers to jobs where their productivity is highest. The current health insurance system distorts that allocation in at least two ways. First, it provides an incentive for workers who place a low value on health insurance received through their jobs to work for firms that do not offer insurance. Second, it raises the cost of labor at firms for which health insurance is more expensive. These distortions lower the efficiency of the labor market and the economy.

The Administration's proposal would eliminate these distortions, but would create a distortion of a different type, in which workers at different wage levels would have an incentive to work for different firms. By contrast, the current system creates no incentive to separate high- and low-skill workers into different firms. And most firms currently include both low-wage and high-wage employees, suggesting that heterogeneous wage (and skill) structures at firms may be more efficient than the homogeneous structures encouraged by the proposal. This efficiency may depend partly on the nature of production processes, which often involve people of different types and levels of skill. It may also depend on the difficulty of conducting transactions through explicit contracts with independent firms rather than informal arrangements within a single firm.

If grouping workers among firms by income or skill level is very inefficient, then the allocation of workers encouraged by the proposal might be less efficient than the current allocation. Also, the process of sorting--of reallocating workers--would entail administrative and organizational costs that would reduce efficiency. But if the efficiency cost of sorting were high, then the speed and ultimate amount of sorting would be relatively low.

What Would Happen to the International Competitive Position of the United States?

When the government makes policy changes as far reaching as the Administration now proposes, one of the biggest concerns of many businesses is how the changes might affect their international competitiveness. CBO's analysis concludes that because the proposal would affect different firms in different ways, some firms would become more competitive and some firms less so. But no solid conclusions can be drawn about whether the overall trade balance would increase or decrease.

Overall Competitiveness: The Balance of Trade

The notion of the "international competitiveness" of the whole economy is hard to define, but what most people mean by it, in practical terms, is a concern that the United States may lose exports or absorb more imports. Working by analogy with an individual firm, it is commonly believed that anything that increases costs would make the balance of trade worse, and anything that decreases costs would improve it. Almost all economists disagree with this view, however, because it neglects some important connections that exist in an entire economy but do not apply to an individual firm.

At a fundamental level, the trade balance of any country is constrained because a country, unlike a firm, can sell abroad only that part of its production that it does not consume or invest itself. Hence, the net amount of sales abroad--the balance of trade--depends most directly, not on costs of production, but on saving and investment.[28] The trade balance improves only if national saving rises, investment falls, or both.

The Administration's health proposal would have indeterminate effects on both national saving and investment. Thus, it is difficult to predict how the proposal would affect the balance of trade.

National Saving. According to CBO's estimates in Chapter 2, the Administration's proposal would marginally raise the federal budget deficit for most of the next decade, though ultimately it would decrease it. A decrease in the federal deficit corresponds to an increase in national saving.

28. Congressional Budget Office, *Policies for Reducing the Current Account Deficit* (August 1989).

The proposal could also affect private saving through several channels. First, universal health insurance would reduce some of the need of individuals to save for precautionary reasons. Precautionary saving arises when individuals are uncertain about, for example, their future income prospects, their life span, or the amount of money they may need to spend on medical services. In the case of medical needs, the amount of precautionary saving would depend on the probability of incurring outlays, the amount of outlays likely to be incurred, and the cost of insurance. It would also depend on income, wealth, and attitudes toward uncertainty. Because the proposal would eliminate the risk of losing insurance and facing large, unexpected medical expenses, it would probably reduce precautionary saving.[29] Of course, the reduction in risk would itself improve people's well-being. Second, some people between the ages of 55 and 64 might save less if the proposal encouraged them to retire earlier. This group, if they continued working, would normally have relatively high saving rates.

At the same time, two factors would work to increase private saving. First, some workers might want to save more during their working years if the proposal encouraged them to retire early. Second, the plan might reduce some people's incentive to spend down their assets if they expected to need Medicaid when they were older. The proposal would allow states to raise the maximum level of assets that single people on Medicaid could keep, thus slightly increasing the incentive to save. Overall, the proposal might reduce national saving somewhat.

Investment. It is even more difficult to predict the effect of the proposal on investment. Because reallocating the burden of health care costs would affect industries very differently, some would increase investment and some decrease it. On net, because it is hard to shift plant and equipment from one firm or industry to another as one contracts and the other expands, such shifts could increase national spending on investment while adjustments occurred. But the effect would be very small: industries are always growing and declining, and the additional shifts as a result of reallocation of health care costs would be difficult to discern. Other factors--especially changes in the health care industry itself--could also affect investment, but it is impossible to predict whether they would cause investment to go up or down. On balance, the effect of the Administration's proposal on investment is uncertain.

The Competitiveness of Different Firms

Under the Administration's proposal, the health care costs of firms that compete directly with foreign firms (the "tradable goods sector") would probably decline. Those firms are much more likely than firms outside that sector to offer health benefits now, and they offer relatively generous benefits.[30] Nevertheless, this reduction in costs would not have much effect on the trade balance.

Although prices might fall, the dollar would rise enough to prevent the change in prices from significantly altering the trade balance. Much of the reduction in health spending would be passed on to workers in the form of higher cash wages. Some firms might pass a portion of their health cost savings through to their prices, depending on the market conditions they face. Thus, the prices of tradable goods could fall on average. But these price declines would probably lead to a strengthening of the value of the dollar relative to foreign currencies. A higher dollar would offset the lower costs in industries dealing with tradable goods, keeping the average price of U.S. goods to foreigners about the same.[31] One result would be to share the lower cost of producing tradable goods with the whole U.S. economy by reducing the cost of imported goods.

29. R. Glenn Hubbard, Jonathan Skinner, and Stephen Zeldes, "The Importance of Precautionary Motives in Explaining Individual and Aggregate Savings," Working Paper 4516 (National Bureau of Economic Research, Cambridge, Mass., November 1993); Martha Starr-McCluer, "Health Insurance and Precautionary Saving" (paper presented at the 1994 annual meeting of the American Economic Association, Boston, Mass., January 1994).

30. See Lewin-VHI, "The Impact of the Health Security Act on Firms Competing in International Markets" (paper presented to the Competitiveness Policy Council, Washington, D.C., December 10, 1993).

31. Henry Aaron and Barry Bosworth, "Health Care Financing and International Competitiveness" (paper presented to the Competitiveness Policy Council, Washington, D.C., December 10, 1993).

As discussed earlier, the Administration's proposal would redistribute insurance costs among different firms and industries, which could alter the prices of their goods and services. These price changes, in turn, could affect the international competitiveness of some companies, although firms whose costs decline by the average for the tradable-goods sector would see no change. For these firms, the reduction of their health costs would be exactly offset by the appreciation of the dollar.

But the international competitiveness of companies with larger-than-average cost reductions would improve. Although the dollar would appreciate, the insurance costs at these companies would fall even more. Firms that have smaller than average reductions--or cost increases--would become less competitive, however.

Conclusion

CBO estimates that the Administration's proposal could cause the number of people working to decline by about one-quarter of a percent to 1 percent, though most of these people would retire or turn to other activities outside the labor market. Unemployment would increase only slightly among minimum-wage workers. A decline in the labor force of that magnitude would reduce the potential market output of the economy by somewhat less, perhaps from 0.2 percent to 0.7 percent. In addition, the proposal would probably cause low-wage workers to move from firms where they would qualify for little or no subsidy to firms where they would attract greater subsidies. Such churning could impose noticeable, though unquantifiable, costs on the economy.

The proposal might also bring into the measured labor force, and measured GDP, some people who are now giving care to their disabled relatives. This would largely be a statistical change and would not significantly alter levels of economic activity.

These predictable changes in the labor force, though important, are in any case small relative to the normal growth and variation in the economy. CBO projects, for example, that the labor force will increase by some 13 percent in the next 10 years, and the predictable effects of the Administration's proposal are well within the range of uncertainty of that estimate. Further, the lower market output of the economy somewhat overstates the economic losses the proposal would cause. Those who left the labor force would engage in other activities--looking after children or enjoying leisure--that have value but are not captured in GDP.

Chapter Five

Other Considerations

The Administration has developed a comprehensive proposal that, if implemented as envisioned by its architects, could alleviate the problems it seeks to address: lack of insurance coverage, lack of access to health care, and rapidly rising health care costs. The proposal's scope is broad, and its attention to detail is extraordinary. It provides a blueprint for restructuring the entire health care system, complete in almost every particular of the design. In this respect it is unique.

As described in Chapter 1, the underlying principles of the proposal would be to establish a universal entitlement to a standard package of health benefits with a financing structure that would build on the existing employment-based system. The proposed system, however, would require all employers to make specified contributions to premiums on behalf of their employees, thereby ending the situation in which some employers in effect pay for the coverage of employees in other firms. All individuals and families, except Medicaid beneficiaries and others with very low income, would also be required to pay at least part of their premiums. Subsidies would be available to help employers and low-income families meet their premium obligations. The Medicaid program as it exists today would end, and Medicaid beneficiaries would enroll in "mainstream" health plans, which would receive the same premium payment for Medicaid beneficiaries as for any other enrollees.

People who had experienced difficulties obtaining health insurance coverage at a reasonable price, and those who feared losing coverage if they lost or changed their jobs, would find that those problems no longer existed. Families with no employed members and employees of small firms would not have to pay higher premiums than others in their community for the same coverage. Employed people would not lose their coverage when they left the labor force. High-risk people in particular would benefit since health status would no longer be a factor in determining the availability of insurance coverage or its price. Most people would have a choice of health plans available to them, which many do not today, and would be provided with information to help them to make informed choices.

To constrain the growth of health care costs, the proposal would establish mechanisms for limiting the rate of growth of premiums for the standard benefit package, and for setting the initial level of premiums in regional alliances. If they were implemented as intended, those mechanisms would be completely effective. The proposal would also attempt to limit federal obligations for subsidies. As discussed in Chapter 2, those limits might not be as effective.

In assessing the likelihood that the Administration's proposal would be able to achieve its goals and establish a stable system for financing health care, two important issues arise: whether it would be possible to implement the proposal fully in the time frame envisioned, and whether there might be unintended consequences that could affect the system's viability.

Policymakers and analysts can only speculate about such questions because of the magnitude of the institutional changes being proposed. The complexity and interrelated nature of the proposal's many components make it difficult to grasp all their possible interactions or to determine the extent of institutional change and development that would be necessary. Moreover, under the proposal an entirely new environment would evolve; the behavior and

expectations of consumers and providers would change in ways that one cannot fully anticipate today. Thus, the potential for unforeseen consequences--both favorable and unfavorable--would be significant.

The Congressional Budget Office's cost estimate, discussed in Chapter 2, assumes that the Administration's restructuring of the health care system would be implemented according to the schedule laid out in the proposal. That assumption may be questionable, however, especially as it relates to the capacity of the agencies that would carry out the program and to the data requirements of the system.

The cost estimate also assumes that the proposed methods for constraining the rate of growth of premiums for the standard health package would be completely effective. Such binding limits could, however, have unintended consequences for the health care system that would affect its overall acceptability and, hence, the sustainability of the limits.

This chapter explores these issues in more depth. The discussion is germane, however, not only to the Administration's proposal but also to any proposal that would involve a major restructuring of the health care system.

Institutional Capabilities and Resources

The organizational structure of the proposed system raises a basic question about its implementation: Would all the agencies involved have the capabilities, experience, and resources needed to undertake their assigned tasks in the time frame envisioned? Many of the critical tasks of setting up the system would be performed by the newly created National Health Board and by the regional alliances, which would be new and untried entities. State and federal agencies would also have major new roles.

The National Health Board would have considerable power and broad responsibilities for the functioning of the entire system, and a large, skilled professional staff would be essential. It would have many difficult tasks to perform--such as establishing a national program for managing the quality of care, developing a national information system for health care, establishing the initial target for the per capita premium for each regional alliance, determining the inflation factor for each regional alliance, estimating the market shares for each health plan in each regional alliance, developing risk-adjustment factors, and recommending modifications to the benefit package.

Moreover, those tasks frequently would have to be performed on extremely tight schedules dictated both by the effective start-up dates and the continuing needs of the proposed system. For example, the board would be required to establish a national program for quality management within one year of enactment and the information system within two years of enactment. On an ongoing basis, the board might have no more than a month in which to determine whether each regional alliance was in compliance with its target for the following year's premiums. After 1996, the board would also have to determine the annual inflation factor and the target for the per capita premium for each regional alliance by March 1 of the preceding year.

The regional alliances--as the frontline agencies responsible for orchestrating the flow of funds through the health care system--would have an even broader, and possibly more demanding, set of responsibilities. They would combine the functions of purchasing agents, contract negotiators, welfare agencies, financial intermediaries, collectors of premiums, developers and managers of information systems, and coordinators of the flow of information and money between themselves and other alliances. They would also have to implement the controls on premiums under the direction of the National Health Board. Any one of these functions could be a major undertaking for an existing agency with some experience, let alone for a new agency that would have to perform them all. Some regional alliances might succeed very well; others might be overwhelmed by these tasks, especially in their early years of operation.

States would also vary in their capability to assume their new responsibilities. Among other

things, they would be asked to develop standards for and certify health plans, establish guaranty funds, and ensure continued coverage for enrollees who had been in health plans that failed. Consequently, the responsibilities of state insurance regulators would probably expand considerably. But the states vary widely in the legal authority of their insurance departments and in the resources that they now devote to the regulation of health insurance. Whether all states would be prepared to undertake all these activities on schedule is therefore uncertain.[1] The three-year phase-in period, however, would give states the opportunity to increase the capacity of their insurance departments before 1998, if they needed to do so.

States would also play important roles in helping the regional alliances to perform their functions. In particular, they would be required to ensure that alliances received the premiums they were owed and help them to determine eligibility for subsidies for premiums and cost-sharing amounts. Since states would be financially liable for error rates above certain limits when determining eligibility for subsidies, they would have strong incentives to assist alliances with that task. Again, however, it is not clear that they would have the needed resources. The proposal would allow states access to information on tax returns from the Internal Revenue Service to assist them in determining eligibility, but many of the people likely to be eligible for subsidies would not be tax filers.

Interstate cooperation would be essential in order for states to meet their responsibilities effectively. Cooperation would be especially important for handling the complications that could arise in metropolitan areas that crossed state boundaries. The proposal recognizes this issue and includes provisions that would permit states to coordinate the activities of two or more regional alliances--including alliances in different states--in such areas as operating rules, enforcement procedures, fee schedules, and contracting with health plans. Setting up these types of arrangements could be difficult but would be important for the effective functioning of some health care markets.

Similar questions of capacity and resources arise with respect to the Department of Health and Human Services (HHS) and the Department of Labor (DOL)--the two federal agencies that would have major responsibilities under the proposed system. Given the reduction in federal employment that is under way, would HHS have the necessary resources to oversee the financial management of regional alliances and to take over the operation of states' systems if they were seriously out of compliance? Would DOL have the capabilities to oversee corporate alliances and to ensure that employers fulfilled their responsibilities in paying premiums and withholding employees' shares? Presumably, the funding necessary to carry out those functions and develop those capacities would be provided through the normal appropriation process. But in a world of limits on discretionary spending, increased resources for those purposes would mean reductions elsewhere.

Information Requirements

The Administration's proposal would depend critically on timely information, much of which has never been collected. Its data requirements fall into three broad categories: those related to the establishment of the parameters of the system that would determine the payments to health plans, those related to managing the quality of care, and those essential for the day-to-day administration and operation of the alliances and health plans. Notwithstanding the ongoing and rapid development of information technology in the health care industry, it is uncertain whether the data essential for decisionmaking would be available in a timely fashion. If they were not or if important information was of poor quality, the functioning of the system could be compromised.

The proposal recognizes the magnitude of these requirements. The National Health Board would be charged with developing and implementing a national health care information system, which

1. See General Accounting Office, *Health Insurance: How Health Care Reform May Affect State Regulation*, Testimony of Leslie G. Aronovitz before the Subcommittee on Health, House Committee on Ways and Means, November 5, 1993, GAO/T-HRD-94-55.

would function through an electronic data network based in regional centers. The information system would provide data to meet multiple requirements in such areas as quality assurance, information for consumers and providers, cost containment, and planning and policy development. Establishing even the framework for such an information system within the two-year time period envisioned by the proposal would be a challenge.

Requirements for Establishing Payment Parameters

The National Health Board would need extensive state and local data to develop the adjustment and inflation factors that it would use to determine the target for the per capita premium of each regional alliance. The data required to establish an effective mechanism for adjusting premiums for risk would also be considerable.

The adjustment factors that would be used to establish the initial target for the per capita premium for each regional alliance are supposed to account for the variations in the health spending and insurance coverage of alliances as well as variations in the proportion of spending by academic health centers. Although data on per capita health expenditures would probably be available for states, whether that information would be available for regional alliances is uncertain. Moreover, reliable information on some of the proposed adjustment factors--such as the proportion of people whose insurance coverage was less generous than the standard benefit package--might not be available even for states.

Initially, calculating the inflation factors would require data on the relative changes in the demographic characteristics (age, sex, socioeconomic status, and health status) of the population of each regional alliance compared with those of the population as a whole. The sample sizes of existing national surveys (such as the Current Population Survey) are too small to produce reliable data of these types for all the regional alliances. Either the sample sizes of existing national surveys would have to be increased, or new regional and local surveys would have to be undertaken. Once the alliances were functioning, however, they would probably collect at least some of the demographic data as part of the enrollment process.

Under the proposed health care system, alliances would have to adjust the per capita payments to health plans to reflect the risk status of their enrollees. If that was not done or was not done well, plans that enrolled higher proportions of sicker or riskier individuals would be at a serious disadvantage competing in the new marketplace, and incentives would be strong for plans to engage in subtle forms of risk selection.

The proposal gives the National Health Board the responsibility for developing a methodology that alliances would use to adjust their per capita payments to health plans for risk. The feasibility of developing an effective risk-adjustment mechanism, however, is highly uncertain and depends on the answers to three questions.[2]

- Would it be possible to develop measures that could distinguish the high use of medical services that resulted because some enrollees were poor risks from the higher use that resulted because health plans were poorly managed?

- How precise would such measures have to be in order to keep risk-selection activities by health plans at minimal levels?

- If effective risk-adjustment measures could be developed, would the information needed to implement them be available to alliances and health plans?

The Administration's proposal recognizes the difficulties that could be encountered. For example, the board would be required to establish by April 1995 a method for adjusting payments to health plans prospectively to reflect the risk status of their enrollees, but the proposal contains an alternative should that task prove to be impossible. Specifi-

2. See, for example, Joseph P. Newhouse, "Patients at Risk: Health Reform and Risk Adjustment," *Health Affairs*, vol. 13, no. 1 (forthcoming); and Testimony of Harold S. Luft, Acting Director, Institute for Health Policy Studies, University of California at San Francisco, before the Subcommittee on Health, House Committee on Ways and Means, November 9, 1993.

cally, the board could develop a mandatory reinsurance system for health plans that would remain in effect until a prospective risk-adjustment system was in place.

Requirements for Managing the Quality of Care

The National Health Board would be required to develop a program for managing the quality of care under the direction of a newly created National Quality Management Council. The council would develop national measures of performance relating to the provision of and access to health care services, the criteria for which the proposal specifies in considerable detail. The council would also conduct surveys on access to health care, use of health services, health outcomes, and patients' satisfaction. It would be responsible for providing an annual report to the Congress on the performance of each alliance and health plan and on trends in the quality of health care.

A fundamental precept of the Administration's proposal--one that is shared broadly by health policy experts--is that information on the performance of health plans and providers should be publicly available and in a standardized form that helps consumers to make informed choices. Accordingly, regional and corporate alliances would be required to provide annual reports on each health plan's performance using the standardized measures, including information about individual providers on some of the measures. Those reports would also include results of surveys of consumers on access, outcomes, and satisfaction.

The specifications in the proposal clearly indicate that tracking quality and performance would be a major undertaking for providers, health plans, alliances, and the board, and would greatly expand current reporting requirements. In addition, an inherent tension would exist between the consumers' need for information on which to base their choices and the demands that would be placed on plans and providers to report the required data.

Requirements for Administration and Operations

In order to carry out their basic functions, health alliances would need extensive management information systems and access to national information networks. They would also need the capabilities to conduct surveys and data analyses, or be able to contract for these services. One has only to review the functions that alliances would have to perform to realize that they would require collecting, maintaining, and updating large amounts of information on individuals, employers, and health plans. Examples include:

- Tracking enrollment and disenrollment in different health plans according to the risk characteristics of enrollees and whether they were receiving Aid to Families with Dependent Children or Supplemental Security Income;
- Determining the eligibility of employers and families for premium subsidies;
- Determining eligibility for reductions in cost-sharing amounts;
- Tracking the amounts of cost-sharing payments for low-income people enrolled in high-cost-sharing plans;
- Monitoring the premium amounts owed by families, taking into account their hours of qualified employment and any changes in their type of family that occurred during the year;
- Monitoring the premium amounts owed by employers; and
- Tracking individuals who were eligible to enroll in the regional alliance--such as students or members of two-worker families--but who enrolled in another alliance, and making appropriate payments to those other alliances on their behalf.

The complexity of tracking the flow of people and dollars across alliances' boundaries highlights

the need for some type of national information system. Determining how much families would owe for their health insurance if they moved between alliances during the year would be particularly difficult. According to the proposal, the regional alliance in which a family was enrolled in December (termed the "final" alliance) would be responsible for collecting any amounts owed by the family, regardless of whether the family had lived in the alliance area for the entire year. All the other alliances in which the family had lived would be required to provide the final alliance with the information necessary to determine the family's total liability. Once the final alliance had collected the amount owed, it would have to distribute it equitably to all the alliances involved. Without an automated tracking system, that would be a monumental undertaking.

In addition to collecting and monitoring financial information on individuals and families, regional alliances would have to estimate the demographic characteristics of their eligible populations, including the number of families of each type, the number of extra workers in couples and two-parent families, the proportion of people enrolled in AFDC and SSI, and the number of people in different risk categories. They would also be responsible for estimating the distribution of enrollment across health plans, as well as the total amount of premiums that employers and families should pay and the expected shortfall in premium payments. Those estimates would be of critical importance to the alliance because they would affect the amounts owed by employers and families, the payments made to health plans, and the amount paid by the federal government for subsidies.

The Effects and Sustainability of Controls on the Rate of Growth of Premiums

Under the proposal, the rate of growth of premiums for the standard benefit package would be severely constrained for the 1996-2000 period, after which the rate of increase would be determined by the Congress or, if it failed to act, by a default procedure tied to real per capita economic growth and inflation in consumer prices.

Limiting the rate of growth of premiums would undoubtedly slow the growth of health spending. Thus, even though the proposal would provide universal health insurance coverage and include several new federal program initiatives, CBO estimates that national health expenditures would increase by 94 percent between 1995 and 2004, compared with a projected increase of 108 percent under the CBO baseline. That represents a reduction of $150 billion in 2004. The projected slower growth of spending would occur because of the restraints on premiums, reductions in the Medicare program, and other features of the proposal.

In preparing its cost analysis, the Congressional Budget Office has assumed that the controls on premiums in the Administration's proposal would be implemented as intended and that the mechanisms used to enforce those limits would effectively restrain spending on the services included in the standard benefit package. But what would be the consequences of that restraint, and could it be sustained?

Some experts believe that the targets for premiums could be largely met by increasing the efficiency of the health care system. According to this view, the system has plenty of "fat"—in the form of excess administrative costs and unnecessary use of services--that would be squeezed out by constraining the growth of premiums. Reductions in administrative costs might be achieved by such measures as standardizing claim forms and developing electronic information systems. The unnecessary use of services might be reduced by increasing enrollment in managed care plans and promoting clinically effective methods of treatment.

By contrast, others maintain that even if efficiency improved greatly, achieving the premium targets exclusively by those means would be extremely difficult and that tight constraints could have undesirable effects on the health care system and might prove to be politically untenable. Possible consequences might include reductions in payments to providers and less access to appropriate services for some consumers. The latter might take

the form of longer waiting times for nonemergency services--including visits to physicians, diagnostic tests, and elective surgeries--and reduced access to new high-cost medical technologies if health plans became more selective about the technologies they adopted. As a corollary, research and development in medical technology might slow, and its focus might shift.

At a general level, both views have merits and limitations. Opportunities undoubtedly exist for lowering administrative costs and reducing inappropriate use of services in the health care system, but trimming unnecessary spending might be difficult without increasing spending elsewhere. For example, although the proposal would streamline many aspects of the administration of health services, it also contains provisions that would entail new administrative costs, such as additional reporting requirements for health plans. Increasing enrollment in tightly managed health care plans--such as group- or staff-model health maintenance organizations--might indeed reduce health spending initially but might have little effect on the rate of growth of spending in the longer run. In addition, some of the methods for reducing the unnecessary use of services--such as promoting effective treatments through the use of guidelines for clinical practice--could also result in increasing the appropriate use of services. Although the effects of the use of guidelines on health spending are uncertain, shifting health care resources from less appropriate to more appropriate uses would almost certainly improve the overall quality of health care.

Whether adverse consequences would result under a constrained system is also uncertain. Lower payments to providers and longer waiting times for some services would not necessarily have negative effects on health outcomes, although providers and some consumers would probably be less satisfied. Furthermore, shifting the focus of research on medical technology could yield positive benefits if manufacturers concentrated more on developing lower-cost substitutes for existing technologies and took the likely effects on costs into account when planning new research initiatives.

Ultimately, however, the effects of constraining the rate of growth of premiums would probably play out more at the alliance than the national level. The new system could encompass perhaps 100 to 200 different regional alliances or markets, each facing a target for its per capita premium. The restrictions on premiums might be more constraining in some markets than in others, because the existing degree of competition in those markets and the extent to which health plans and providers have already achieved greater efficiencies vary widely. The limits, therefore, might be much harder to meet in some areas than in others. Furthermore, the effects of the constraints on spending in any particular market would depend on the interrelated behavioral responses of health plans, employers, providers, and consumers in that market to the new incentives in the health care system.

In short, the full effects of limiting the rate of growth of premiums would be highly uncertain. In part, that uncertainty would arise because the restraint on premium growth would occur in a restructured health care system, operating under new incentives and with insurers and health plans facing new forms of restrictions as well as new opportunities. Uncertainty would also stem from the heterogeneity of the regional alliance markets and the probable variation in the ways their health care systems would adapt to restraints on spending.

The fact that limits on the rate of growth of premiums might begin to bite at different times and in different ways in each of the various alliances raises the issue of the political sustainability of those limits: Would the public and policymakers view them as an acceptable way to restrain health care spending? The situation would be particularly difficult because of the wide variation that currently exists in health spending across the country--at least some of which reflects differences in patterns of medical practice and competitive pressures in the marketplace.

On the one hand, to the extent that historical spending is used as the basis for determining the initial level of premiums in regional alliances, limits on the rate of growth of premiums will build in the inequalities in current spending. Some analysts argue that such an approach would be unfair to regions in which the health care system has already become "leaner" and more efficient, since those

regions would have a harder time meeting the growth targets (because they have less "fat" to trim). On the other hand, ignoring historical spending levels and instead establishing initial premium or spending levels according to some objective criteria reflecting need and differences in input prices could cause major disruptions within the health care system in some regions that currently have high rates of use.

The Administration's proposal has recognized both aspects of the problem. The National Health Board would attempt to adjust the regional alliances' targets for premiums to reflect current differences in health spending and insurance coverage. Although this approach would build on historical spending patterns, it would be modified by including the adjustment for insurance coverage. In other words, current spending patterns would be adjusted to account for low spending in an area that may reflect the population's lack of insurance coverage.

The per capita amounts for Medicaid, as well as states' maintenance-of-effort payments for current Medicaid beneficiaries who would no longer be eligible for the program, would also be based on historical spending. In the case of Medicaid, historical differences in per capita spending among regions may reflect differences in covered benefits and in reimbursement rates for providers, as well as variations in access to and use of services.

Under the proposal, the board would be required, by July 1995, to make recommendations to the Congress on:

- Eliminating, by 2002, the variation in regional alliances' targets for per capita premiums that resulted from variations in practice patterns; and

- Reducing, by 2002, the variation in the payments that states would make for beneficiaries receiving cash assistance and for maintenance of effort that resulted from differences in practice patterns, historical differences in the rates of reimbursement to providers, and the amount, duration, and scope of benefits covered by Medicaid.

The Congress would be required to conduct an expedited review of the board's recommendations, which would go into effect unless a joint resolution of disapproval was passed within 60 days. The board's recommendations would be of extreme interest to policymakers because they might have the effect of raising the allowed premium levels in some areas and lowering them in others. The board might also recommend that some states pay more than in the past for Medicaid beneficiaries and maintenance of effort and that others pay less.

CBO's analysis has assumed that the limits on the rate of growth of premiums would be sustained even though they are likely to create immense pressure and considerable tension. Such strains, however, would not be peculiar to the Administration's approach. Other methods of restraining the rapid growth of health care spending would be likely to generate similar stresses.

Conclusion

Fundamental reform of the nation's health care system will inevitably involve many uncertainties. New institutions will be required, and new responsibilities will be imposed on existing institutions. Their abilities to perform will be in doubt. The behavior of providers and consumers will change as incentives are altered. The magnitude and even the direction of these changes are difficult to foresee.

The ramifications and consequences of even incremental approaches to reform are not easy to predict. The complexity of the existing system and the intense interest all Americans have in health care issues make it difficult to anticipate the outcome of even modest changes in existing programs. For example, most policymakers badly misjudged the political response to the Medicare Catastrophic Care Act, and analysts seriously underestimated the fiscal consequences of recent changes in the Medicaid program.

As the Congress considers the Administration's proposal and other alternatives for systemic and incremental reform, the inherent uncertainties of change must be weighed against the detrimental consequences that flow from the current system--increasing numbers of people who lack the security of insurance coverage for health care and the rapidly rising costs of that care.

Summaries of Recent Health Care Analyses by the Congressional Budget Office

The Congressional Budget Office (CBO) publications listed below are available to Congressional staff and the general public. To obtain copies, call CBO's Publications Office at (202) 226-2809.

Evaluating the Costs of Expanding the CHAMPUS Reform Initiative into Washington and Oregon (CBO Paper, November 1993, 46 pp.)

In 1988, the Department of Defense (DoD) began the CHAMPUS Reform Initiative (CRI) as a test of managed care in the military. In August 1993, DoD proposed extending a revised version of CRI to Washington and Oregon, certifying to the Congress that CRI would be the most efficient method of providing health care to the two states. As required by law, this paper reviews DoD's analysis. CBO's findings suggest that the revised CRI benefit is likely to cost more than DoD has estimated.

Behavioral Assumptions for Estimating the Effects of Health Care Proposals (CBO Memorandum, November 1993, 37 pp.)

To estimate the effects of proposals to change the health care system, CBO must make assumptions about the behavioral responses that might occur as a result of new policies. This memorandum draws on the best available research to develop a set of guidelines on which to base CBO's estimates. These guidelines will be revised as new evidence appears.

Projections of National Health Expenditures: 1993 Update (CBO Memorandum, October 1993, 22 pp.)

This memorandum provides projections of national health expenditures through 2003. It updates the tables and figures in CBO's study *Projections of National Health Expenditures* (October 1992) based on the methods described in that study and consistent with CBO's September 1993 economic assumptions and baseline budget projections.

Controlling the Rate of Growth of Private Health Insurance Premiums (CBO Memorandum, September 1993, 27 pp.)

This memorandum analyzes two illustrative policy options that are intended to highlight some of the key issues surrounding the regulation of health insurance premiums. The first option is a "stand-alone" measure to limit the rate of increase in private health insurance premiums. The second option incorporates additional policy measures that could mitigate some of the potential adverse effects of a stand-alone policy. (The two options are not based on any specific legislative proposal.)

Estimates of Health Care Proposals from the 102nd Congress (CBO Paper, July 1993, 57 pp.)

The 103rd Congress will be considering a wide range of proposals to expand access to health care and control costs while maintaining quality, and

CBO will have to estimate the effects of these proposals on the federal budget. This paper illustrates CBO's approach to preparing such estimates by examining four health reform bills introduced during the 102nd Congress: H.R. 1300, sponsored by Congressman Russo, establishing a single-payer system; H.R. 5502, sponsored by Congressmen Stark and Gephardt, expanding Medicaid and Medicare and setting overall limits on national health expenditures; H.R. 5919, introduced by the House Republican leadership, embodying much of President Bush's health reform program; and H.R. 5936, introduced by Congressman Cooper and other members of the Conservative Democratic Forum, establishing regional purchasing cooperatives for health insurance and a federal program to subsidize the purchase of private insurance by low-income people.

Trends in Health Spending: An Update (CBO Study, June 1993, 91 pp.)

Since the early 1960s, national health expenditures have risen rapidly despite many attempts to control their growth. This study examines trends in the market for health services since 1960 to provide background information and a context for assessing proposals to change the U.S. health care system. The report focuses on increases in the costs of hospital services, physician services, and drugs and other medical nondurable items. It also compares trends in health spending by the nation with trends in Medicare spending.

Managed Competition and Its Potential to Reduce Health Spending (CBO Study, May 1993, 58 pp.)

This study looks at whether managed competition could constrain spending on health care by motivating consumers, insurers, and providers to be more cost-conscious. The report identifies eight features that are critical for achieving the full savings that managed competition could potentially deliver, including health insurance purchasing cooperatives, caps on contributions by employers, and standardized benefits.

Responses to Uncompensated Care and Public-Program Controls on Spending: Do Hospitals "Cost Shift"? (CBO Paper, May 1993, 45 pp.)

During the 1980s, the revenues that hospitals received for treating Medicare and Medicaid patients declined, on average, relative to what it cost hospitals to treat those patients. CBO looks at the extent to which hospitals were able to cover their costs of uncompensated care and their unreimbursed costs of treating Medicare and Medicaid patients during the 1980s with subsidies from state and local governments; sources other than patient care, such as revenues from hospitals' parking facilities and donations; and revenues from private patients.

Single-Payer and All-Payer Health Insurance Systems Using Medicare's Payment Rates (CBO Memorandum, April 1993, 60 pp.)

The United States is a leader in medical research and has the ability to deliver health care of the highest quality, but critics find fault with two aspects of the system: a substantial number of people lack health insurance coverage, and health care costs are high compared with countries where coverage is universal. CBO examines two approaches by which both universal health insurance coverage and greater control over health care costs might be achieved. The first approach is a single-payer system in which all covered health care services are insured and paid for by a single insurer, and the second is an all-payer system in which services are covered and paid for by multiple insurers but all payers adopt the same payment methods and rates.

Projections of National Health Expenditures (CBO Study, October 1992, 70 pp.)

The rapid growth of spending on health care will not decrease in the 1990s unless the present health care financing and delivery system is changed. This CBO study reviews the growth in national health spending since 1965, describes CBO's methodology for projecting national health expenditures, and ana-

lyzes trends in spending by type of spending and source of funds.

Economic Implications of Rising Health Care Costs (CBO Study, October 1992, 70 pp.)

This study, a companion to the one above, analyzes how rising health care costs significantly affect the economy by squeezing household and government budgets, distorting the labor market, and diverting resources from other priorities. Because the current health delivery system lacks a mechanism to match benefits with costs, spending on health may not reflect the preferences of either consumers or society. Instead, many factors--detailed in this study--seem to encourage excessive health spending. CBO finds that workers have borne most of the costs of employer-provided insurance in the form of lower real wages and reduced nonmedical benefits. Over the 1973-1989 period, these health costs have gobbled up more than half of the real gains in workers' compensation.

The Potential Impact of Certain Forms of Managed Care on Health Care Expenditures (CBO Memorandum, August 1992, 31 pp.)

This memorandum looks at what might happen to national health expenditures and to spending under Medicare, Medicaid, and private health insurance if all acute care services now funded through insurance arrangements were provided through delivery systems incorporating two specific forms of managed care. One is staff-model and group-model health maintenance organizations. The other is "effective" forms of utilization review, which CBO interprets to mean utilization review that incorporates precertification and concurrent review of inpatient care.

The Potential of Direct Expenditure Limits to Control Health Care Spending (CBO Memorandum, July 1992, 17 pp.)

This memorandum describes various approaches to using expenditure limits to control health spending and identifies some of the operational issues that would be involved.

The Effects of Managed Care on Use and Costs of Health Services (CBO Memorandum, June 1992, 32 pp.)

This memorandum assesses the evidence about the effect of managed care organizations and interventions on the use and costs of health services--both for the affected populations and for the entire health care system--focusing on managed care for acute care services.

Selected Options for Expanding Health Insurance Coverage (CBO Study, July 1991, 100 pp.)

About one in seven Americans lacks health insurance. This study explores three options to expand health insurance coverage for the uninsured: mandating job-based coverage, expanding the Medicaid program, and combining the two. Each of these options could substantially reduce the ranks of the uninsured and keep most existing insurance arrangements intact, the study finds, but spending on health care could rise considerably.

Rising Health Care Costs: Causes, Implications, and Strategies (CBO Study, April 1991, 110 pp.)

This study describes the economic factors that contribute to the growth in health spending and examines what is known about the effectiveness of different strategies for achieving greater control over costs. The five strategies examined by the study are cost sharing by consumers; managed care that limits the freedom of health care providers and consumers; price controls; efforts to increase competition among insurers and providers; and regulation of the market for health services, including controls on capital and uniform payment systems that encompass all payers.

Updated Estimates of Medicare's Catastrophic Drug Insurance Program (CBO Study, October 1989, 73 pp.)

This study estimates the cost to Medicare of covering outpatient prescription drugs as required by the Medicare Catastrophic Coverage Act of 1988. The methodology described in this report remains applicable to estimates of proposals to provide a prescription drug benefit under Medicare.

CBO/HSA

February 21, 1994

MEMORANDUM FOR DISTRIBUTION

FROM: MEEGHAN PRUNTY

SUBJECT: Good Quotes from CBO Analysis of HSA

The attached document is a compilation of all of the positive quotes from the CBO analysis as well as the two days of testimony that were on the wire. Positive quotes from the media were also included. Please use this as a reference or source for whatever talking points, speeches, memos, etc. you may be working on. I put them in about 20 categories and, in most cases, left the entire quote in to be edited as your document dictates.

If you need to use it, it is on the i drive under: i\data\hlthcare\goodquo4.cbo

[Chris, Jack, Steve -- I am happy to update this with Reischauer's first day of testimony if Ways and Means ever makes it available.]

DISTRIBUTION: Bob Boorstin, Steve Edelstein, Debbie Fine, Christine Heenan, Harold Ickes, Chris Jennings, Greg Lawler, Jack Lew, Mike Lux, Ira Magaziner, Lynn Margherio, Lorrie McHugh, Jason Solomon, Gene Sperling, George Stephanopoulos, Melanne Verveer

POSITIVE CBO QUOTES
Index

- Achieve President's Goals
- Alternate Bills
- Business Costs Will Be Reduced
- Choice Will Increase for Most Americans
- Cost Shift Eliminated
- Deficit Reduction
- Difference Between Estimates Is Small
- Families Will Benefit
- Hospitals (DSH)
- Job Loss Negligible
  - Re. NFIB Analysis
- Medicare Savings Are Achievable
- National Health Expenditures
- Numbers Uncertain / Hard to Predict / Long-Term Important
- On-Budget / Off-Budget Issues
- Praise for Administration
- Praise for Lewin Study
- Small Businesses Will Benefit
- Warning to Opponents of Reform
- Universal Coverage / Comprehensive Care
  - Why Universal Coverage?
- Worker's Wages Will Increase
- Why Not 100+ Alliances?

POSITIVE CBO QUOTES

ACHIEVE PRESIDENT'S GOALS:

- **Mitchell Exchange**

"SEN. MITCHELL: Mr. Reischauer, the president has stated as his principal objectives in health care reform achieving universal health insurance coverage, that is, every American having health insurance; reducing health care spending as a percentage of the gross domestic product; and achieving long-term deficit reduction. While your estimates differ from those of the administration's and you describe those differences as modest, am I correct in my understanding that your report supports the president's conclusions as to those principal objectives? . . .

MR. REISCHAUER: If it's implemented according to the legislative language, that is correct; it would achieve all three of those objectives. . . .

SEN. MITCHELL: So -- so that if I may summarize your responses to these three questions, if the president's plan were adopted and implemented, all Americans would be insured against the crisis of health care --

MR. REISCHAUER: Yes.

SEN. MITCHELL: -- health care spending as a percentage of the gross domestic product would decline --

MR. REISCHAUER: Yes.

SEN. MITCHELL: -- long-term deficit reduction would be achieved --

MR. REISCHAUER: Yes.

SEN. MITCHELL: -- cost to business would decline by $90 billion in the year 2004 -- estimated --

MR. REISCHAUER: Estimated, yes.

SEN. MITCHELL: -- and the wages of American workers would increase by an amount close to $90 billion a year.

MR. REISCHAUER: Correct.

SEN. MITCHELL: So that all Americans would be insured, the deficit would be going down, health care spending as a percentage of the Gross Domestic Product would be going down, and the wages of American workers would be increased by up to or close to $90 billion a year. Is that correct?

MR. REISCHAUER: That is the judgment that we reached." [Reischauer Testimony, Senate Finance Committee, 2/9/94]

- **Dingell Exchange**

"REP. DINGELL: Does the proposal provide comprehensive health coverage for all Americans?

MR. REISCHAUER: Yes, it does.

REP. DINGELL: Does the proposal increase health care choices for most Americans?

MR. REISCHAUER: In my judgment, it would.

REP. DINGELL: Does the proposal lower the rate of increase of health care costs?

MR. REISCHAUER: Yes, it would.

REP. DINGELL: Does the proposal reverse the current cost-shifting trend?

MR. REISCHAUER: Yes, it would.

REP. DINGELL: Can you tell us briefly what is the overall effect on the U.S. economy? Do wages rise in the real sense?

MR. REISCHAUER: Real wages should be positively affected by the plan, yes." [Reischauer Testimony, *House Subcommittee on Health*, 2/10/94]

- "The CBO credited the administration with coming up with a framework that appears to reconcile what many had considered irreconcilable: extending health care to all Americans while at the same time slowing the growth of medical costs, which threaten to consume 20 percent of the nation's economic output by the end of the decade." [Pearlstein and Broder, Washington Post, 2/9/94]

- "[The CBO analysis] is a significant acknowledgment that health reform can do what is necessary; that is, provide health coverage for all Americans while containing sky-rocketing health-care costs." [USA Today, 2/9/94]

- "[CBO] said his plan will provide insurance coverage for all Americans, reverse the tide of soaring health care costs, yield long-term deficit reduction, reduce costs to business by $90 billion, raise wages for employees, offer a greater choice of doctors, and result in negligible job loss." [Wolf, USA Today, 2/10/94]

ALTERNATE BILLS:

- "The Health Security Act is unique among proposals to restructure the health care system . . . the proposal outlines in legislation the steps that would actually have to be taken to accomplish its goals. No other proposal has come close to attempting this. Other health care proposals might appear equally complex if they provided the same level of detail as the Administration on the implementation requirements." (emphasis added) ["An Analysis of the Administration's Health Proposal", CBO, 2/9/94, p. xv]

- "These are very legitimate concerns but, again, they are not peculiar to the Health Security Act. Any proposal attempting to restructure the current health care system would face similar issues." [Congressional Budget Office, "An Analysis of the Administration's Health Proposal", 2/8/94]

- "As the Congress considers the Administration's proposal and alternatives, both comprehensive and incremental, the inherent uncertainties of change must be weighed against the detrimental consequences of the current system--increasing numbers of people who lack the security of insurance coverage for health care and the rapidly rising costs of that care." [Congressional Budget Office, "An Analysis of the Administration's Health Proposal", 2/8/94]

- **Single Payer:**
  "In fact, in my discussion with the Ways and Means Committee members yesterday, Mr. McDermott pointed out that, in fact, it would have roughly the same slowing-down effect that a single-payer plan would have." [Reischauer Testimony, Senate Finance Committee, 2/9/94]

- **Managed Competition Bills:**
  "Breaux-Durenberger-Cooper-Cooper plan does this by imposing a pretty hefty tax on employer-paid premiums above a certain level. That's going to create tensions, too." [Reischauer Testimony, Senate Finance Committee, 2/9/94]

- **Cooper**
  "And, by our estimate, it would -- at the end of the projection period -- lead to covering only one-third of the people who were uninsured in our estimate." [ref to 102nd bill] [Reischauer Testimony, House Subcommittee on Health, 2/10/94]

BUSINESS COSTS WILL BE REDUCED:

- "But businesses' costs for health care would be significantly reduced overall . . For example, the total premiums employers would pay for active workers would drop by about $20 billion in the year 2000." ["An Analysis of the Administration's Health Proposal", CBO, 2/9/94, p. xiii]

- "But businesses' costs for health care would be significantly reduced overall, both because the proposal would provide substantial subsidies to firms and because it would limit the growth of premiums." [Congressional Budget Office, "An Analysis of the Administration's Health Proposal", 2/8/94]

- "[The President's proposal] would sharply reduce the growth of employer spending for health insurance. By 2004, employers would save about $90 billion for active workers and more than $15 billion for early retirees... " ["Analysis of the Administration's Health Proposal", CBO, 2/9/94]

- "Overall, businesses' costs for health insurance would be significantly reduced by the proposal. Businesses' insurance premiums for active workers would drop by about $90 billion below our baseline level in the year 2004. . . Universal coverage would mean that those firms that now offer insurance would not longer need to pay indirectly through higher doctor and hospital bills for the care given to uninsured workers and their families. On the other hand, firms that do not now provide insurance could not longer ride free." [Reischauer Testimony, Senate Finance Committee, 2/9/94]

CHOICE WILL INCREASE FOR MOST AMERICANS:

- "REP. DINGELL: Does the proposal increase health care choices for most Americans?

  MR. REISCHAUER: In my judgment, it would." [Reischauer Testimony, House Subcommittee on Health, 2/10/94]

- " . . most Americans will have a rather broad choice of health plans. And if they're dissatisfied with one, they could move into another."[Reischauer Testimony, House Subcommittee on Health, 2/10/94]

COST SHIFT ELIMINATED:

- "Universal coverage would mean that those firms that now offer insurance would not longer need to pay indirectly through higher doctor and hospital bills for the care given to uninsured workers and their families. On the other hand, firms that do not now provide insurance could not longer ride free." [Reischauer Testimony, Senate Finance Committee, 2/9/94]

- "REP. DINGELL: Does the proposal reverse the current cost-shifting trend?

  MR. REISCHAUER: Yes, it would." [Reischauer Testimony, *House Subcommittee on Health*, 2/10/94]

DEFICIT REDUCTION:

- "[CBO Chairman Reischauer said] significant deficit reduction will be achieved by 2004." [UPI, 2/9/94]

- "And finally, as I noted earlier . . . the proposal should make ever-increasing contributions to deficit reduction after 2004." [Reischauer Testimony, Senate Finance Committee, 2/9/94]

- "By 2004, however, the estimated effects on the deficit are negligible, and CBO believes that the proposal holds the promise of reducing the deficit in the long term." [Congressional Budget Office, "An Analysis of the Administration's Health Proposal", 2/8/94]

- "By 2004, CBO estimates that the proposal would have no appreciable effect on the deficit. If we had the ability to project further into the future, we would presumably see that the proposal would reduce the deficit by growing amounts after 2004." [Reischauer Testimony, Senate Finance Committee, 2/9/94]

- "SEN. MITCHELL: -- long-term deficit reduction would be achieved --

  MR. REISCHAUER: Yes." [Reischauer Testimony, Senate Finance Committee, 2/9/94]

- "[This] difference of opinion may have more political than economic significance: Both predict that the Clinton plan will begin saving money for the government, business, and consumers by the year 2000." [Pearlstein and Broder, Washington Post, 2/9/94]

DIFFERENCE BETWEEN ESTIMATES IS SMALL:

- "The difference between these estimates is small, however, compared with the uncertainty surrounding the budget projections." [Congressional Budget Office, "An Analysis of the Administration's Health Proposal", 2/8/94]

- "Some of the numbers will seem large when examined in isolation, but when compared to the size of the economy, the baseline level of national health expenditures, government spending on Medicare and Medicaid, and even the deficit, they may be relatively trivial." [Reischauer Testimony, Senate Finance Committee, 2/9/94]

- "Some might be tempted to exaggerate the importance of this difference, so let me place these numbers in their proper context. First, $126 billion is less than 6 percent of both the deficits accumulated over the past decade and the deficits that we project for the next 10 years. Second, $126 billion represents less than 3 percent of the projected federal spending on Medicare and Medicaid during the next 10-year period. Third, the number should be balanced against the advantage of living in a nation in which no one lacks health insurance coverage. And finally, as I noted earlier, if the premium restraints are adhered to, the proposal should make ever- increasing contributions to deficit reduction after 2004." [Reischauer Testimony, Senate Finance Committee, 2/9/94]

- "[Reischauer] also went out of his way to call the differences in financial estimates `relatively small potatoes in the great scheme of things.'" [Pear, New York Times, 2/9/94]

FAMILIES WILL BENEFIT:

- "And if all this happens, of course, according to the bill and our estimates, Americans will have more money in their pockets to spend both on private items -- food, clothing, entertainment, travel, whatever -- and on public services as well." [Reischauer Testimony, House Subcommittee on Health, 2/10/94]

- "The Clinton plan, when compared to today's system, would cost average Americans less money, give them more health benefits and more choice of physicians and medical care, [Reischauer] said." [Priest and Rich, Washington Post, 2/9/94]

HOSPITALS (DSH):

- "Well, remember, one reason we have the disproportionate share payment is that we have a lot of individuals trooping into our hospitals or being carried into our hospitals who don't have any insurance coverage and this is a bad debt problem, an uncompensated care problem for these hospitals. This plan and any other plan that provides for universal coverage, of course, means that many of those individuals now placing a tremendous burden on these hospitals would have insurance coverage. The hospitals would be reimbursed for that care that they're providing, and they'd be reimbursed at higher rates of reimbursement relative to the average than is now the case under the Medicaid program." [Reischauer Testimony, *House Subcommittee on Health*, 2/10/94]

- "And so I don't think this is an area where anybody would argue the situation isn't going to get better for that class of hospitals." [Reischauer Testimony, *House Subcommittee on Health*, 2/10/94]

- "But it's paying it for lots of folks who will have insurance coverage now, and so these hospitals, in fact, are going to be better off for those groups of people that they treat now who don't have insurance coverage." [Reischauer Testimony, House Subcommittee on Health, 2/10/94]

JOB LOSS NEGLIGIBLE:

- "Taking all of these labor market reactions together, CBO estimates that eventually between one-quarter and one percent of the labor force might prefer to stay home under the proposal, but I should add that CBO does not expect there to be a significant impact on the unemployment rate." [Reischauer Testimony, Senate Finance Committee, 2/9/94]

- "Well, what we're saying is that the size of the labor force might diminish somewhat, between a quarter of a percentage point and one percentage point, **eventually, in the long run, 15, 20 years**. It will decline largely because some individuals will take advantage of the incentive to retire early because they will get health insurance coverage as early retirees." (emphasis added) [Reischauer Testimony, Senate Finance Committee, 2/9/94]

- "The impact of these changes on aggregate labor supply is likely to be quite small. . ." [Reischauer Testimony, *House Subcommittee on Health*, 2/10/94]

- ". . . somewhere between one quarter of 1 percent and 1 percent of the labor force might prefer to stay home under this proposal. But I should add, as a number of you have mentioned, that CBO does not expect there to be any significant impact on the unemployment rate." [Reischauer Testimony, House Subcommittee on Health, 2/10/94]

- "The Clinton plan, [CBO] concluded, would not significantly slow the economy or result in the loss of jobs, as many critics have charged." [Pearlstein and Broder, Washington Post, 2/9/94]

- " . . . [the proposal] would alter the unemployment rate little." [CBO, "An Analysis of the Administration's Health Proposal", 2/9/94, p.51]

- "Plus there will be some job creation probably because of the expansion of home and community-based health care for the disabled." [Reischauer Testimony, *Senate Finance Committee*, 2/9/94]

- "Finally, some welfare recipients might be enticed into the labor force because of the proposal's incentives." [Reischauer Testimony, *House Subcommittee on Health*, 2/10/94]

- "Rather, the major impact would be voluntary early retirement . . ." [Reischauer Testimony, House Subcommittee on Health, 2/10/94]

Re. NFIB Analysis: ". . . Do you believe that the administration's bill will result in a loss of 3.1 million jobs, as the NFIB contends?

MR. REISCHAUER: No, I don't, and I think the estimates that you refer to are highly exaggerated. They often come from a kind of logic that is flawed." . . [Reischauer Testimony, House Subcommittee on Health, 2/10/94]

MEDICARE SAVINGS ARE ACHIEVABLE:

- "Medicare program. And you know, those costs I think -- our savings, in fact, are quite real and quite achievable." [Reischauer Testimony, House Subcommittee on Health, 2/10/94]

NATIONAL HEALTH EXPENDITURES:

- "The numbers that I provided for you on national health expenditures indicates that it will slow down the rate of growth of national health expenditures by a substantial amount." [Reischauer Testimony, Senate Finance Committee, 2/9/94]

- "Thus, CBO projects that national health expenditures would fall $30 billion below the current CBO baseline by calendar year 2000, and would be $150 billion (7 percent) below that baseline in 2004." ["An Analysis of the Administration's Health Proposal", CBO, 2/9/94, p. xii]

- "Once the administration's proposal was fully implemented it would significantly reduce the projected growth of national health expenditures." [CBO, 2/9/94, p. 26]

- ***Initial rise, then fall:*** ". . . national health expenditures will rise by between 1 percent and 3 percent above our baseline projections during the period which the alliance system is being phased in. The increase is the inevitable consequence of extending coverage to millions of uninsured Americans, increasing the generosity of the benefits that many currently insured people enjoy and expanding services for the disabled. By 2000, the limits placed on the growth of premiums and the Medicare savings are sufficient to reduce national health expenditures some $30 billion below our baseline level. By the year 2004, national health expenditures should be some $150 billion or 7 percent below the baseline level." [Reischauer Testimony, House Subcommittee on Health, 2/10/94]

NUMBERS UNCERTAIN / HARD TO PREDICT / LONG-TERM IMPORTANT:

- "Focusing on the effects of proposals in their early years is, therefore, not very meaningful; it is the long-term impacts, when new coverages would be fully phased in and the system stabilized, that are important." ["An Analysis of the Administration's Health Proposal", CBO, 2/9/94, p. xiii]

- "The first of these is the great uncertainty that surrounds all estimates of this proposal and estimates of all other systemic reform initiatives." [Reischauer Testimony, Senate Finance Committee, 2/9/94]

- ". . . and as I pointed out in our report, you have to weigh that uncertainty against the knowledge that you have that staying the course with the existing system is going to create an increasingly serious set of health care problems in this country, more and more people being uninsured." [Reischauer Testimony, Senate Finance Committee, 2/9/94]

- ". . . it will take some time before the full consequences of the proposed system play themselves out." [Reischauer Testimony, Senate Finance Committee, 2/9/94]

- "For these reasons your attention should focus on the long-term effects of the proposal." [Reischauer Testimony, Senate Finance Committee, 2/9/94]

ON-BUDGET / OFF-BUDGET ISSUES:

- "First let me say the ``T" word has not crossed my lips, nor will it." [Reischauer Testimony, Senate Finance Committee, 2/9/94]

- "But a more important thing, which I would urge on this committee: you should design a health care plan that makes sense, that effectively achieves the objectives you want to achieve, and not get all caught up in whether it would -- on the budgetary treatment." [Reischauer Testimony, Senate Finance Committee, 2/9/94]

PRAISE FOR ADMINISTRATION:

- "The administration has put forward the most far-reaching piece of social legislation since President Roosevelt proposed the Social Security Act some 60 years ago." [Reischauer Testimony, Senate Finance Committee, 2/9/94]

- "Lots of individuals at OMB, at HCFA, at HHS were there to help us understand the intricacies of this bill, to tell us how they did their estimating, which, as far as I can tell, really was done without any bias at all, was a first-rate professional effort to get at these costs." [Reischauer Testimony, Senate Finance Committee, 2/9/94]

PRAISE FOR LEWIN STUDY:

- ". . . the Virginia-based consulting firm Lewin-VHI in its excellent study of the president's plan." [Reischauer Testimony, Senate Finance Committee, 2/9/94]

PREMIUM CAPS ARE EFFECTIVE:

- "We examined the premium limits that are in the bill and we regarded them to be an effective mechanism for restraining the growth of premiums for this basic benefit package." [Reischauer Testimony, Senate Finance Committee, 2/9/94]

- "I mean that the premium caps will effectively set limits on the costs of this basic package of benefits." [Reischauer Testimony, Senate Finance Committee, 2/9/94]

SMALL BUSINESSES WILL BENEFIT:

- "[The proposal] would benefit smaller firms that typically pay much higher premiums than larger firms. This leveling of costs could benefit all small businesses -- not just those that provide insurance today. With access to more affordable insurance, small businesses would be better able to attract workers who now demand health insurance as a condition of employment." ["An Analysis of the Administration's Health Proposal", CBO, 2/9/94, p. 54]

WARNING TO OPPONENTS OF REFORM:

- "Mr. Chairman, let me close by noting that some might use the information contained in our report in destructive rather than constructive ways. That would be tragic. Thanks to the courage and efforts of the president, we are once again trying to grapple with a serious national problem, one which presidents from both parties -- Harry Truman, Richard Nixon, Jimmy Carter, and George Bush -- tried to address. Each of them was stymied, however, because the solutions are so complex and because health reform unavoidably involves significant redistribution, a topic that our society does not like to deal with directly. But we must remember both that the problems inherent in the current health financing system will only grow worse if nothing is done and that the current system already contains huge amounts of redistribution, most of which is invisible and much of which is inequitable and distortionary." [Reischauer Testimony, Senate Finance Committee, 2/9/94]

- "Let me close by saying that I hope very sincerely that the information contained in the CBO's report will be used in constructive ways, in ways that advance the debate on how we can reform our health care system -- our system of health care financing. Presidents Truman, Nixon, Carter, and Bush all tried to address this major national problem, but all were stymied. With each passing year, the problem only deepens and the solutions only become more difficult." [Reischauer Testimony, House Subcommittee on Health, 2/10/94]

- "Thanks to the courage and efforts of President Clinton, the Congress has another chance to craft a solution to this serious national problem. It would be tragic if we failed to take advantage of this opportunity." [Reischauer Testimony, House Subcommittee on Health, 2/10/94]

- "I have considerable foreboding that the information contained in my statement and the CBO report might be used in destructive rather than constructive ways -- that is, it might be used to undercut a serious discussion of health reform alternatives or to gain some short-term partisan political advantage," Reischauer said. He warned that the debate on this issue too often degenerated into "semantic mud wrestling and name calling." [SOURCE??, 2/9/94]

UNIVERSAL COVERAGE / COMPREHENSIVE CARE:

- ". . . there will obviously be universal coverage, it will be successful -- number one." [Reischauer Testimony, Senate Finance Committee, 2/9/94]

- "REP. DINGELL: Does the proposal provide comprehensive health coverage for all Americans?

  MR. REISCHAUER: Yes, it does." [Reischauer Testimony, House Subcommittee on Health, 2/10/94]

WHY UNIVERSAL COVERAGE?

- "Well, what we have said in a number of our reports is that as long as you're going to have insurance pay for a lot of health care, bringing everybody into the tent is a first step towards rationalizing the system, because if everybody isn't under the insurance tent, then what you do will have detrimental impacts in the sense that changes in incentives on the folks with insurance will manifest themselves in cost shifting off onto others or increased numbers of people lacking health insurance, those with health insurance having to pick up the cost, and so on." [Reischauer Testimony, *House Subcommittee on Health*, 2/10/94]

WORKER'S WAGES WILL INCREASE:

- "And to the extent that business' costs are reduced, these will result in higher wages. The vast preponderance of that $90 billion would be passed on to workers in the form of higher wages." [Reischauer Testimony, Senate Finance Committee, 2/9/94]

- "SEN. MITCHELL: -- and the wages of American workers would increase by an amount close to $90 billion a year.

  MR. REISCHAUER: Correct." [Reischauer Testimony, Senate Finance Committee, 2/9/94]

- " . . the lion's share of those savings would be returned to workers in the form of higher cash wages. . . " ["An Analysis of the Administration's Health Proposal", CBO, 2/9/94, p. 35]

- "First, the proposal would increase the cash wages of U.S. workers . . ." ["An Analysis of the Administration's Health Proposal", CBO, 2/9/94, p. 51]

- "Thus, the significant savings that the Administration's proposal would produce compared with current policy would be largely passed on to workers in the form of higher wages." [Congressional Budget Office, "An Analysis of the Administration's Health Proposal", 2/8/94]

WHY NOT 100+ ALLIANCES?

- ". . . you are diluting the effect of community rating when you do that, because what will happen is only employers with below-average risk pools will be forming corporate alliances. And those employers that have older, less healthy workers or workers' families will all be in the regional alliance. So we'll sort of have one basket of good eggs and a basket of bad eggs, and we will have in a sense a two-tier system. And it's a very different one from the one that the president has proposed." [Reischauer Testimony, House Subcommittee on Health, 2/10/94]

[i:\data\hlthcare\goodquo4.cbo; 02/21/94 06:43 PM]