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Jennifer Klein

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December 9, 1993

TO: Interested Parties

FR: White House Health Care Team

On December 8, 1993, the independent research group, Lewin-VHI released a study that shows the soundness of the financing of the President's Health Security Act. The study confirms that the Health Security Act is fully financed and that it will reduce the deficit over the period from 1995-2000.

Included in this packet are:

1. A copy of the Lewin-VHI executive summary
2. A copy of the Lewin-VHI press release
3. Formal statement by Deputy OMB Director Alice Rivlin
4. Transcript of briefing conducted by Treasury Secretary Lloyd Bentsen and OMB Director Leon Panetta.
5. Selected newspaper articles

If you need more information, please feel free to contact the Health Care Delivery Room at 202-456-2566.

EXECUTIVE SUMMARY

President Clinton's health reform proposal, the Health Security Act, would fundamentally reshape the United States health care system. The Health Security Act assures that all Americans have access to comprehensive health insurance coverage and clearly defines the roles of employers, governments, and individuals in financing this coverage. The Act also redefines the role of insurers in providing coverage to all Americans while realigning the provider incentives that have contributed to the rapid rate of growth in health spending in the United States. Moreover, it would, for the first time, place limits on the growth in health spending through a combination of price competition and premium growth limits over time.

In this analysis, we focus upon the financing implications of the President's health reform plan. We present estimates of changes in health spending by employers, governments, and individuals under the plan in 1995 through 2000. We also compare our estimates with those developed by the administration.

A. Overview of the Health Security Act

The Act establishes quasi-public entities called "Health Alliances" in each region of the country which aggregate consumer buying power to negotiate the best premiums with health plans. In general, all persons not otherwise covered under

Medicare would select from among alternative plans offered through the Health Alliance. These plans would be required to offer a uniform benefits package covering a standard list of services with standardized patient cost-sharing requirements. These plans are also required to accept all applicants and are not permitted to vary premiums with health status ("community rating"). This market structure limits insurers' ability to target healthier populations, thus forcing insurers to compete for market share on the basis of price, provider network, and quality of services provided. All states are required to participate in the program by 1998, although states are permitted to participate as early as 1996.

OVERVIEW

- *In general, all persons not covered under Medicare obtain coverage through a program of Health Alliances*
- *Medicaid recipients participate in Health Alliances*
- *Employers must contribute to coverage for workers and dependents*
- *Non-workers must purchase coverage*
- *Premium subsidies provided for low-income persons and certain employers*
- *Prescription drug coverage under Medicare*
- *Expanded long-term care coverage*
- *Controls on overall health spending*

The Financial Impact of the Health Security Act

Employers are required to contribute at least 80 percent of the cost of the average plan in the area for each full-time worker, leaving the employee to pay the remainder. (The employer has the option of contributing more.) Non-working individuals also obtain coverage through the program. The Act provides premium subsidies to low-income individuals and employers (primarily small firms with lower wage workers). In addition, the Federal government will pay 80 percent of the average cost premium for early retirees. However, these subsidies are provided only up to an amount equal to the average cost plan in the area to encourage consumer price consciousness when selecting a plan.

AVERAGE ANNUAL PREMIUMS IN REGIONAL ALLIANCE IN 1998	
Individuals	\$2,732
Couples	\$5,464
Two-Parent Families	\$5,975
One-Parent Families	\$5,172

Medicaid coverage would be continued for persons receiving cash assistance although they would obtain coverage through the Health Alliance. Medicaid coverage would be eliminated for all other persons not receiving cash assistance (except those on Medicare); these individuals would obtain coverage through the Health Alliance where they will qualify for subsidies according to the same criteria that apply to other families. However, states are required to make a "maintenance of effort" contribution to the Federal government to fund subsidies under the program the amount of which is based upon the state share of savings for the non-cash Medicaid population.¹

Under the Act, the Medicare program is retained in its current form, although coverage is extended to cover prescription drugs. Long-term care coverage is also expanded under the Act. However, working Medicare recipients would become covered in the Regional Alliance by virtue of the employer coverage requirement. In addition, the program includes provisions which limit the growth in health spending for both public and private programs by controlling the rate at which premium payments could increase.

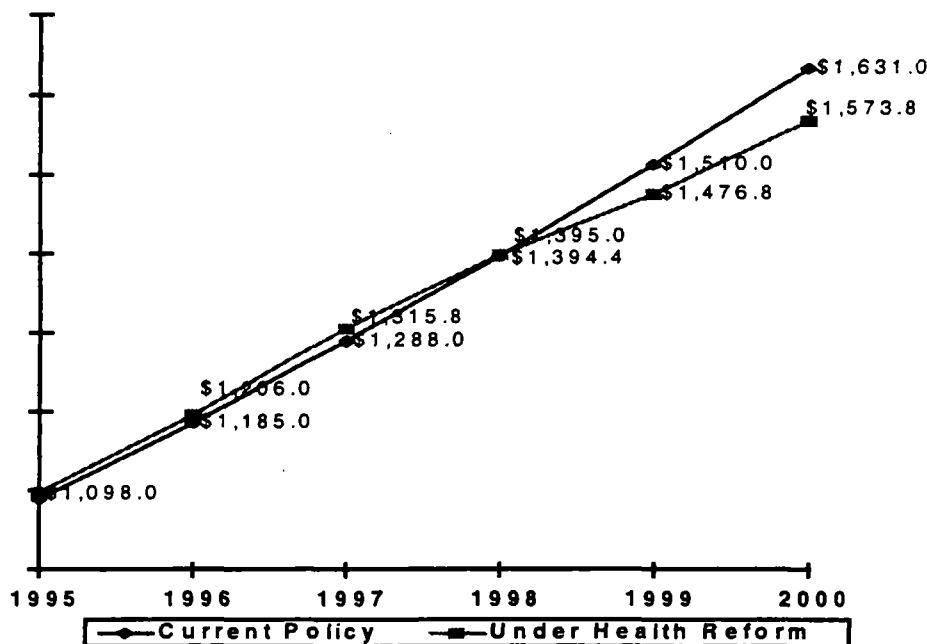
B. Change in National Health Spending

National health spending would increase over the 1996 through 1998 period as states begin to participate under the program and extend coverage to the uninsured (Figure ES-1). Under the Act, health spending would eventually fall below levels projected under current

¹ The amount of this maintenance of effort contribution will be based upon current spending for the non-cash Medicaid population indexed to health spending growth (i.e., reflects budget caps).

policy beginning in 1999 as the effect of the health expenditure constraints increases over time. Under the Health Security Act, health care will comprise about 18.0 percent of gross domestic product (GDP) by 2000 compared with 18.7 percent under current policy (without reform).

FIGURE ES-1
CHANGES IN HEALTH SPENDING UNDER THE HEALTH SECURITY ACT IN 1995
THROUGH 2000



Source: Lewin-VHI estimates using the Health Benefits Simulation Model (HBSM).

Health spending in the first full year of implementation (1998) would be roughly the same as under current policy (\$0.6 billion less) (Table ES-1). However, as discussed below, health spending by individual payers will change substantially under the Act. The \$0.6 billion reduction in health spending reflects an array of complex changes in coverage and service delivery under health reform. This includes increases in utilization of acute care services for previously uninsured persons of \$47.0 billion; increased long-term care utilization of \$11.6 billion; increased funding for public health of \$5.4 billion; and increased administrative costs of \$6.9 billion. These new costs will be offset by savings attributable to increased use of managed care.

TABLE ES-1
CHANGES IN HEALTH SPENDING IN 1998 (IN BILLIONS)

CHANGES IN HEALTH SPENDING		CHANGE IN HEALTH SPENDING
<i>Federal Government Health Spending</i>		\$6.0
New Program Costs	\$76.4	
Offsets to New Program Costs	(\$70.4)	
<i>State Government Health Spending</i>		(\$12.4)
New Program Costs	\$1.2	
Offsets to New Program Costs	(\$13.6)	
<i>Local Government Health Spending</i>		\$3.4
Savings to Public Hospitals	(\$14.8)	
Loss of Disproportionate Share Funds	\$16.6	
Local Government Worker Health Benefits	\$1.6	
<i>Private Employer Health Spending (Net of Subsidies)</i>		\$28.9
Firms That Now Insure	(\$0.4)	
Firms That Do Not Now Insure	\$29.3	
<i>Household Health Spending</i>		(\$26.5)
Premiums Payments	(\$26.2)	
Out-of-Pocket Payments	(\$15.8)	
Tax Payments	\$15.5	
NET CHANGE IN HEALTH SPENDING		
Net Change in Spending b/		(\$0.6)
Utilization for Uninsured/Underinsured	\$47.0	
Managed Care Savings	(\$14.9)	
Long-Term Care	\$11.6	
Public Health	\$5.4	
Administration	\$6.9	
Expenditure Control Savings	(\$56.6)	

a Does not include wage effects and resulting changes in tax payments because these values are not included in the national health accounts. These effects are estimated below.

b A detailed analysis of changes in national health spending under the Health Security Act is presented in Appendix A.

Source: Lewin-VHI estimates.

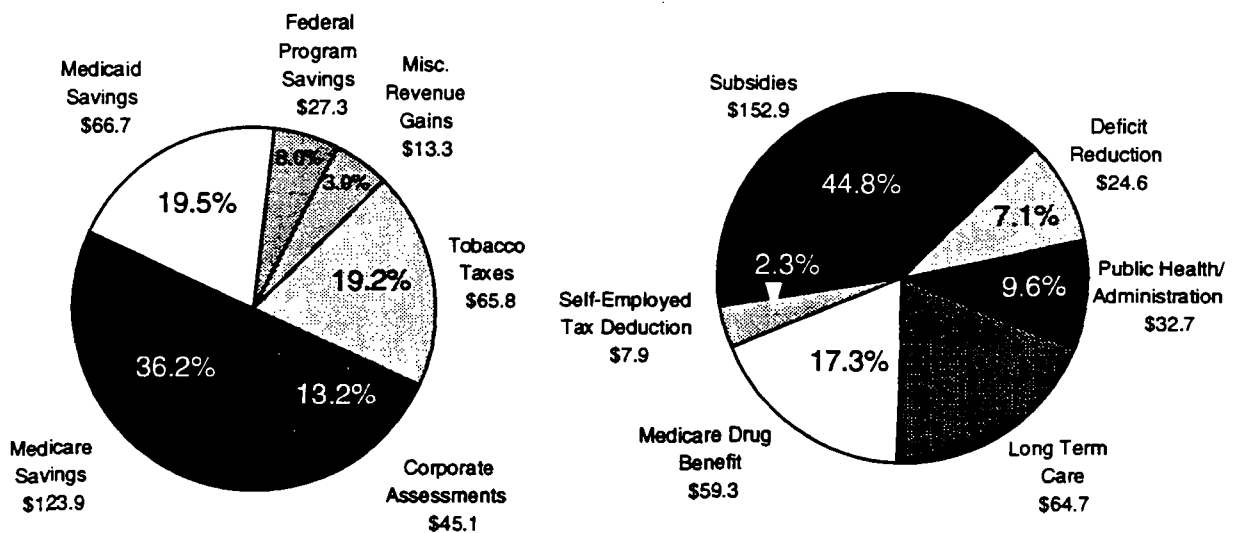
C. Federal Health Spending Under the Health Security Act

New Federal programs under the Health Security Act would be financed largely with savings in existing Federal health benefits programs. The Federal government would provide premium subsidies to households and businesses, expand long-term care coverage, provide prescription drug coverage under Medicare, and expand public health activities. These programs would be financed with savings under Medicare, Medicaid and other Federal programs together with other taxes on households and employers. Under the assumptions used in this analysis, the program would result in a net reduction in the Federal deficit over the 1994 through 2000 period of about \$24.6 billion.

The Financial Impact of the Health Security Act

Total uses of Federal funds under the Health Security Act would be \$342.1 billion over the 1994 through 2000 period (Figure ES-2). This includes new program spending of \$317.5 billion and \$24.6 billion in deficit reduction. The \$317.5 billion in new program spending includes premium and cost-sharing subsidies (net of offsets) of \$152.9 billion; net Medicare drug benefit payments of \$59.3 billion; and long-term care expenditures of \$64.7 billion. The program also includes \$7.9 billion in increased health insurance tax deductions for self-employed persons, and funding for public health and administration of \$32.7 billion.

FIGURE ES-2
SOURCES AND USES OF FEDERAL FUNDS UNDER THE HEALTH SECURITY ACT
1994 - 2000 (IN BILLIONS)



Sources of Funds = \$342.1

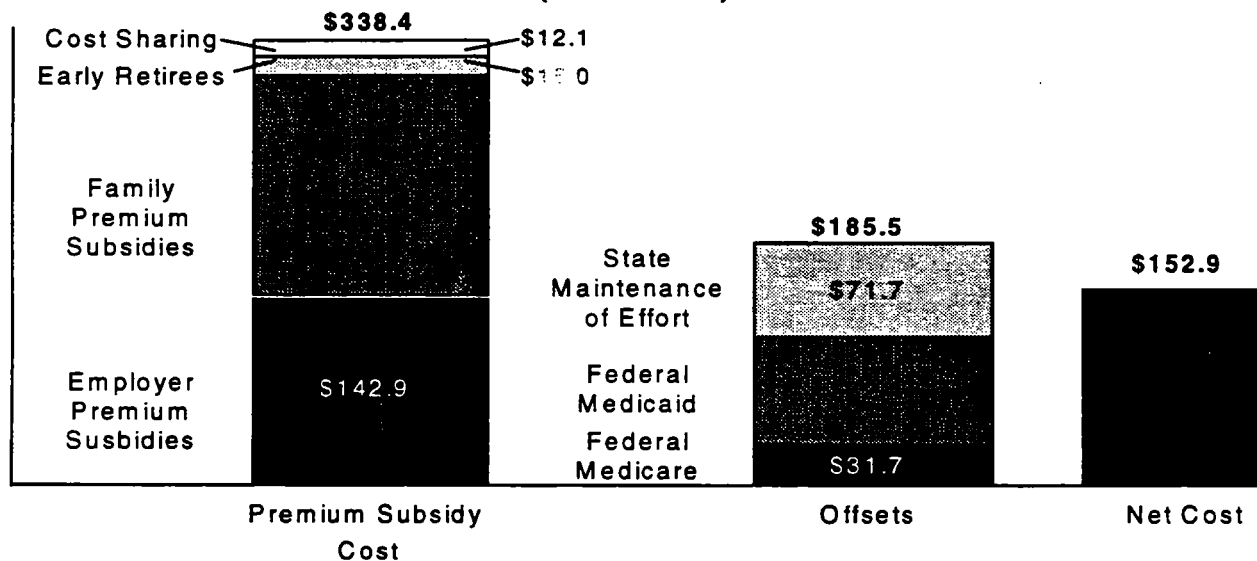
Uses of Funds = \$342.1

Total funding under the Health Security Act would be \$342.1 billion over the 1994 through 2000 period. About two thirds of these funds would be raised through savings in existing programs such as Medicare, Medicaid, FEHBP, Veterans and other programs. These savings reflect the impact of the premium cap, shifts in coverage from public programs to private plans and Medicaid savings resulting from the elimination of Disproportionate Share Payments (DSH) to hospitals. About 36 percent of the program would be financed through new tax revenues of which about half would be attributed to a three fold increase in Federal excise taxes on tobacco products (\$65.8 billion). The program would also be financed partly by corporate assessments of \$45.1 billion. This includes the one percent payroll tax paid by

employers who elect to form a Corporate Alliance and employer savings for early retirees receiving subsidized coverage under the Act.²

A major portion of new spending under the Act will be Federal subsidies to businesses and households of \$152.9 billion. Total subsidy payments would be \$338.4 billion over the 1996 through 2000 period which includes: employer premium subsidy payments of \$142.9 billion; premium subsidies to families of \$168.4 billion; cost-sharing subsidies of \$12.1 billion; and early retiree subsidies of \$15.0 billion (Figure ES-3). These costs will be offset by: 1) Medicare savings for working aged persons covered under the Health Alliance (\$31.7); 2) the Federal share of savings for the Medicaid non-cash recipients shifted to the Health Alliance (\$82.1); and 3) state maintenance of effort payments for the non-cash Medicaid population shifted to the Health Alliance (\$71.7 billion).

FIGURE ES-3
SUBSIDY PAYMENTS UNDER THE HEALTH SECURITY ACT: 1996 THROUGH 2000
(IN BILLIONS)



Source: Lewin-VHI estimates using the Health Benefits Simulation Model (HBSM).

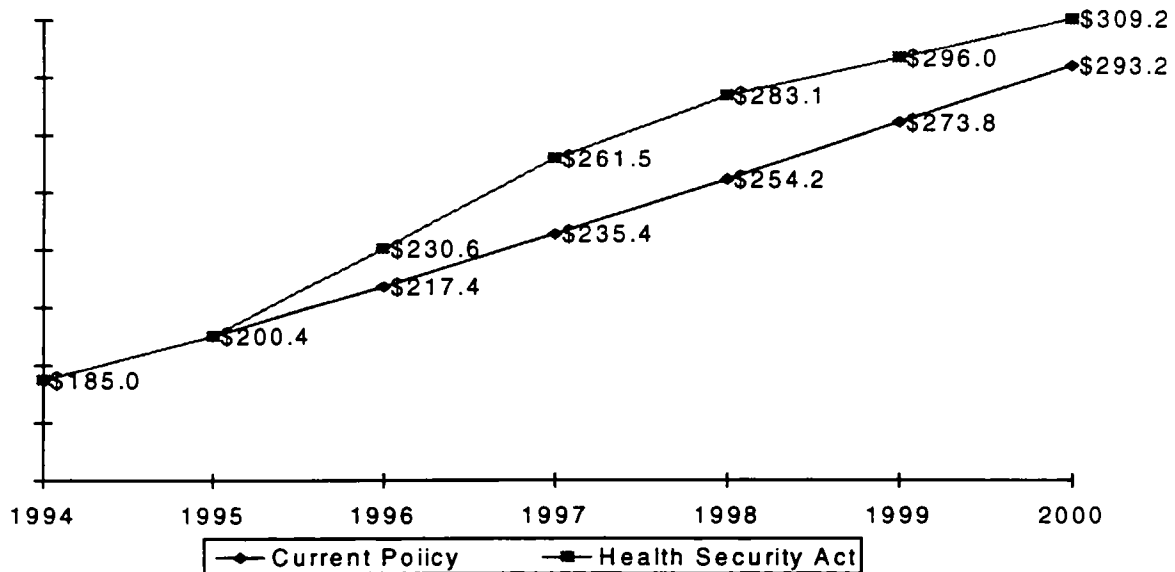
D. Employer Health Spending

Private employer health spending (net of subsidies) would increase gradually over the 1996 through 1998 period as states participate in the Health Alliance (Figure ES-4). The net increase in employer spending in the first full-year of implementation would be \$28.9 billion.

² Firms with 5,000 or more workers are permitted to form a Corporate Alliance but must pay a one percent payroll tax beginning in 1996. We assume that firms with unionized workplaces will elect this option as will other eligible firms that will find it to their advantage to do so.

Employer health spending would continue to be higher than projected under current law through the end of the century. However, the rate of growth in private employer health spending would be substantially lower than under current projections due to the premium caps.

FIGURE ES-4
PRIVATE EMPLOYER HEALTH SPENDING UNDER CURRENT POLICY AND THE HEALTH SECURITY ACT (IN BILLIONS)^a

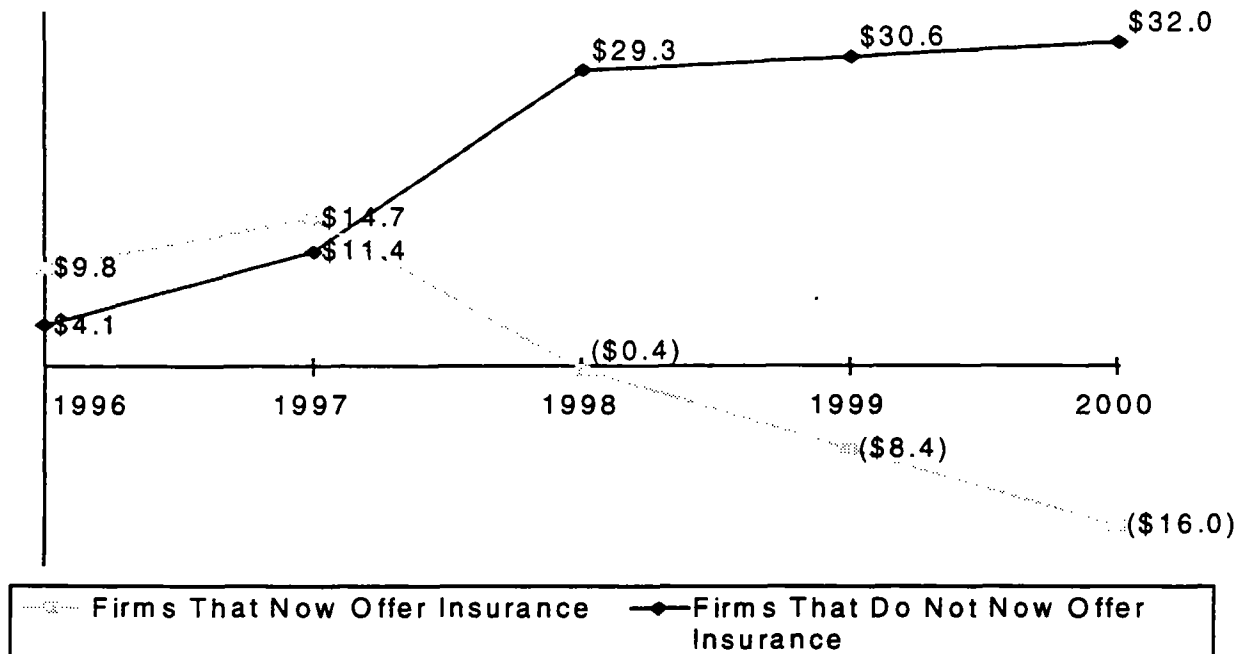


a Includes benefits for workers, dependents, and retirees net of program subsidies.
Source: Lewin-VHI estimates using the Health Benefits Simulation Model (HBSM).

The increase in employer spending under the Act reflects the cost of covering workers who currently do not have coverage on their job offset by cost containment savings under the Act. Among employers who now offer insurance, costs would increase initially due to the cost of covering workers now excluded from coverage in these firms, the cost of upgrading coverage to the minimum standard under the Act, and the one percent payroll tax paid by firms that decide to form a Corporate Alliance. Once all states participate under the Act in 1998, spending for these firms would decline below currently projected levels due to: 1) cost controls; 2) Federal coverage of early retirees under the Health Alliance; and 3) the fact that coverage for working dependents in employer plans would in effect be financed by his/her own employer resulting in savings to firms that now provide insurance (Figure ES-5).³

³ The federal government will pay 80 percent of the Alliance premium for early retirees resulting in savings to employers who provide early retiree benefits.

FIGURE ES-5
CHANGE IN EMPLOYER HEALTH SPENDING FOR FIRMS OFFERING AND NOT OFFERING INSURANCE



a Includes benefits for workers, dependents, and retirees net of program subsidies.
 Source: Lewin-VHI estimates using the Health Benefits Simulation Model (HBSM).

Smaller firms that now offer insurance will tend to see a reduction in health spending due to the higher level of premium subsidies provided to these groups. For example, insuring firms with less than ten workers save an average of about \$868 per worker under reform. Among firms that do not now offer insurance, employer spending would increase by about \$1,908 per worker. Among firms that now provide insurance, expenditures will decline in industries such as construction, manufacturing, transportation, wholesale trade, and finance.

E. Impact on State and Local Government Health Spending

State and local governments are a major source of financing for many programs that provide care to low-income and medically indigent populations. These programs, especially at the state level, will generally see substantial savings under the Health Security Act as coverage is extended to all Americans. However, the discontinuation of Disproportionate Share Hospital (DSH) payments under Medicaid will have a significant impact on many hospitals that are heavily dependent upon DSH payments. The employer coverage requirement could also result in a significant increase in expenditures for many state and local governments that do not now cover substantial portions of their public employee workforce.

State and local government health spending would be reduced by about \$9.0 billion in 1998 under the Health Security Act. State government expenditures would be reduced by about \$12.4 billion in 1998 due to savings in Medicaid and other indigent care programs sponsored by state governments. Local government spending would actually increase by about \$3.4 billion in 1998 largely due to the loss of DSH payments to public hospitals and the cost of conforming to the employer coverage requirement for government workers under the Act.

F. Impact on Households

The Health Security Act would affect households in four ways. First, the plan generally would result in substantial changes in family premium payments. Second, expanded coverage under the plan would generally reduce family direct payments for care. Third, lower-income households would receive subsidies for patient cost-sharing and household premium payments. Fourth, the Act would result in increased tax payments resulting from the excise tax on tobacco products and the exclusion of health benefits from cafeteria health plans.

In 1998, overall health spending by households would be reduced by about \$26.2 billion under the Act (Table ES-2). Family premium payments would be reduced by about \$25.9 billion and direct payments for care (copayments, uncovered services) would decrease by about \$15.8 billion. These savings would be offset by increased tax payments of about \$15.5 billion, about two-thirds of which would be due to an increase in tobacco taxes under the Act.

The Financial Impact of the Health Security Act

**TABLE ES-2
IMPACT OF HEALTH REFORM ON HOUSEHOLDS IN 1998 (IN BILLIONS)**

		CHANGE IN SPENDING
PREMIUM PAYMENTS		
Employee Share of Employer Premium		(\$15.2)
Payments to Alliance a/	\$62.9	
Premiums Under Current Plans b/	(\$74.7)	
Worker Premium Subsidies c/	(\$4.9)	
Premium for Supplemental Benefits d/	\$1.5	
Non-Employment Premiums		(\$14.9)
Premiums to Alliance e/	\$57.5	
Non-Group Premiums Under Current Policy f/	(\$26.6)	
Premium Subsidies e/	(\$45.8)	
MEDICARE PREMIUM		
Medicare Part B Premium g/		\$3.9
Increased Premium for Higher Income Persons	\$1.1	
Part-B Spending Cap	(\$1.6)	
Prescription Drug Program	\$4.4	
DIRECT PAYMENTS FOR CARE		
Direct Payments		(\$15.8)
Out-of-Pocket Spending for Acute Care h/	(\$15.9)	
Direct Payments for Long-Term Care i/	(\$1.6)	
New Copayments Under Medicare j/	\$5.0	
Patient Cost Sharing Subsidies k/	(\$3.3)	
TAX PAYMENTS		
Tax Changes		\$15.5
Tobacco Taxes	\$10.8	
State and Local HI Tax Payments l/	\$0.7	
Cafeteria Plan Restrictions m/	\$4.1	
Reduced Medical Expense Deduction n/	\$2.3	
Deduction for Self Employed o/	(\$2.4)	
NET CHANGE IN HOUSEHOLD SPENDING		
Net Change in Spending		(\$26.5)

- a The employer is required to pay an amount equal to at least 80 percent of the average cost plan in the area with the employee paying the remainder.
- b Premium payments for existing coverage are eliminated.
- c Premium subsidies are provided to workers below 150 percent of poverty.
- d Some employers are assumed to continue coverage for services not covered under the minimum benefits package at the current employee premium contribution level for these benefits (e.g., adult dental, eyeglasses).
- e Non-workers not otherwise covered under Medicare are required to purchase coverage through the Health Alliance. Subsidies are provided for lower-income families.
- f The subsidized non-worker coverage provided under the Health Alliance eliminates the need for other non-group insurance payments for this population.
- g Medicare premiums are increased for higher income persons. The premium is increased to cover roughly 25 percent of the cost of the prescription drug benefit. This premium increase will be partly offset by premium reductions due to the budget cap.
- h Family out-of-pocket payments for health services will be reduced under the program due to: 1) reduced patient cost-sharing requirements under the plan and 2) expanded coverage for services often excluded under existing plans.

Footnotes continued on next page

The Financial Impact of the Health Security Act

- i Includes tax incentives for long-term care insurance.
- j Includes increased copayments for home health and laboratory services.
- k The program reduces patient cost-sharing for persons below 150 percent of poverty.
- l All state and local workers will be required to pay the Medicare HI tax (individual share).
- m Increased personal incomes taxes due to exclusion of health benefits from cafeteria plans.
- n Reductions in direct payments for care will lead to reduced medical expense income tax deductions.
- o The insurance deduction for self-employed persons will result in reduced tax payments for some persons.

Source: Lewin-VHI estimates using the Health Benefits Simulation Model (HBSM).

The greatest decline in health spending would occur among older persons. Health spending for persons age 55 to 64 would decline by about \$782 per family, largely due to the retiree coverage provision and prescription drug coverage for the Medicare disabled population. Health spending would decline by \$487 among families headed by a person age 65 or older, again largely due to prescription drug coverage. Among persons who would spend \$10,000 or more out-of-pocket under current policy, family spending would be reduced by about \$6,093 per family

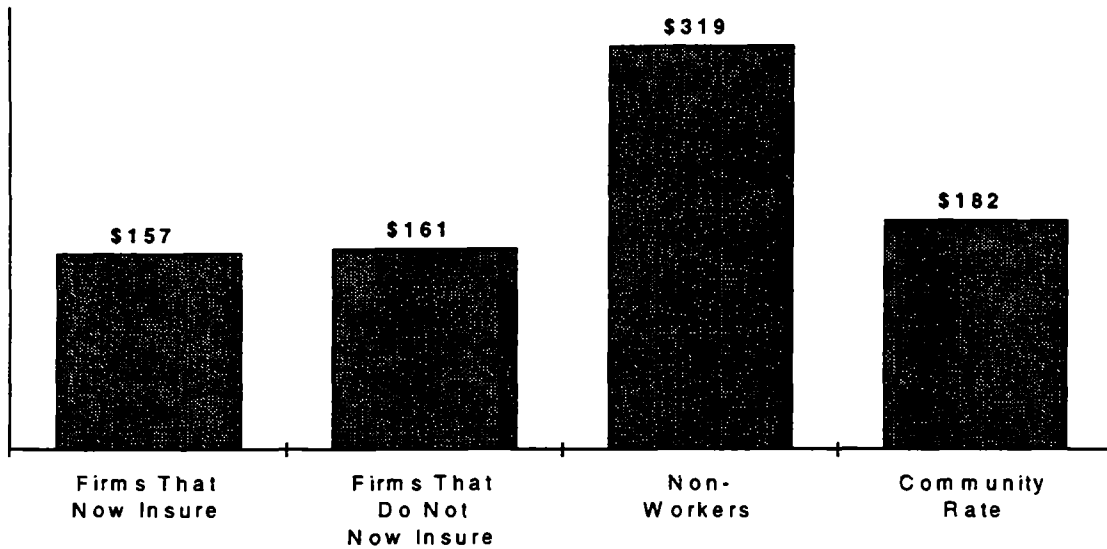
The plan would reduce spending across all family income groups except those with incomes of \$100,000 or more. Families with annual incomes below \$10,000 would see savings of about \$742 per family. Average savings would generally decline as income rises. Health spending would increase by an average of \$289 per family for families with incomes of \$100,000 or more largely due to the increase in premiums for high income Medicare beneficiaries and the exclusion of health benefits from cafeteria plans.⁴

G. The Importance of Community Rating

Under the Act, all individuals in a given health plan pay the same premium for their type of family (i.e., individual, two-parent family, etc.) regardless of their age or health status. This means that younger healthier populations will cross-subsidize the cost of care for older and sicker groups. In particular, it implies that employers and workers will cross-subsidize non-workers. For example, the average monthly per capita cost of the uniform benefits package would be roughly \$160 for workers and dependents while the monthly per-capita for non-workers, would be about \$319 (Figure ES-6). The overall community rated per-capita premium would be about \$182 per month, which is about 14 percent higher than the actual cost for workers and dependents.

⁴ The Act prohibits employers from including employee contributions for health insurance and other health expenses in tax exempt cafeteria plans, resulting in an increase in tax revenues (after adjusting for likely shifts in compensation to other non-taxable forms of compensation).

FIGURE ES-6
AVERAGE MONTHLY PREMIUM COST PER PERSON UNDER THE REGIONAL ALLIANCE
IN 1998



Source: Lewin-VHI estimates using the Health Benefits Simulation Model (HBSM).

This employer cross-subsidy of non-workers reduces substantially the Federal cost of assuring universal coverage. This is because the non-worker population, which includes early retirees and Medicaid non-cash recipients shifted to the Health Alliance, will generally receive premium subsidies under the Act. However, due to this community rating cross-subsidy, the Federal government will subsidize premium purchases for non-workers at \$182 per month rather than at their actual cost of \$319 per month. Thus, in effect, employers and the Federal government share in the cost of insuring the lower income non-working population. This is one of the primary reasons why the Federal cost of assuring universal coverage under the Act is less than might have been expected. It is also one of the primary reasons why employer health spending would remain well above currently projected levels into the next century despite constraints on the rate of growth in health spending.

H. Distributional Impacts

A comprehensive reform of the U.S. health care system such as the Health Security Act will involve a substantial realignment and standardization of coverage affecting both employers and individuals. This will inevitably result in net changes in health spending for many employers and individuals.

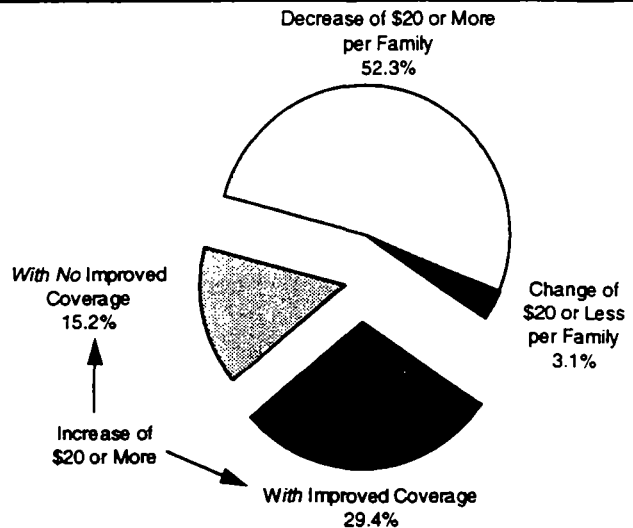
About 52 percent of all households would see a reduction in annual health spending under the Act of \$20 or more (Figure ES-7). About 29 percent of families would see an

FIGURE ES-7
DISTRIBUTIONAL IMPACTS OF HEALTH REFORM ON HOUSEHOLDS AND EMPLOYERS
IN 1998

IMPACT ON HOUSEHOLDS

Families Whose Spending Would Decrease By:	All Households	Percent in Group With Improved Coverage
\$1,000 or More	23.2%	72.3%
\$500 - \$1,000	10.4%	62.3%
\$250 - \$500	7.8%	58.2%
\$100 - \$250	6.2%	54.0%
\$20 - \$100	4.7%	45.8%

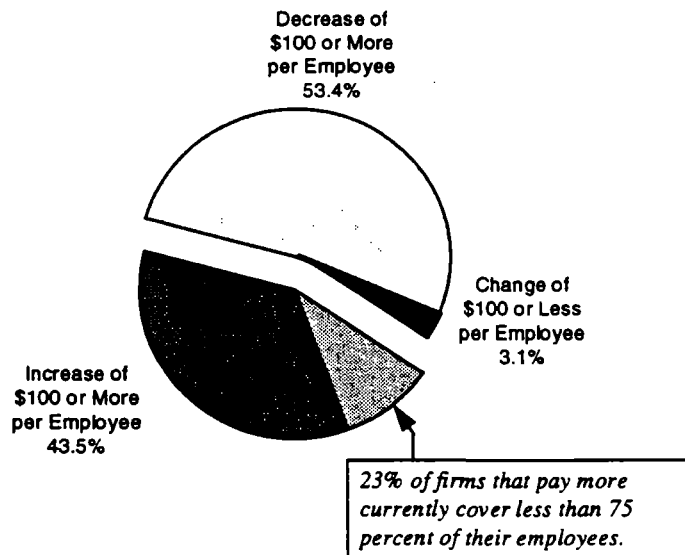
Families Whose Spending Would Increase By:	All Households	Percent in Group With Improved Coverage
\$1,000 or More	14.6%	79.7%
\$500 - \$1,000	11.5%	86.2%
\$250 - \$500	8.2%	77.1%
\$100 - \$250	6.5%	63.6%
\$20 - \$100	3.8%	56.4%



IMPACT ON EMPLOYERS WHO NOW PROVIDE INSURANCE^B

Businesses That Would Decrease Annual Employee Spending By:	
\$2,500 or More	16.3%
\$1,000 - \$2,500	15.8%
\$500 - \$1,000	11.8%
\$250 - \$500	7.5%
\$100 - \$250	2.0%

Businesses That Would Increase Annual Employee Spending By:	
\$2,500 or More	0.5%
\$1,000 - \$2,500	20.5%
\$500 - \$1,000	12.5%
\$250 - \$500	6.4%
\$100 - \$250	3.6%



- a Includes changes in premiums, out-of-pocket expenses, and taxes earmarked to fund health reform. Excludes institutionalized persons.
- b Includes the impact of premium subsidies and changes in retiree expenses. Counts based upon number of employers so that each employer holds the same weight in this analysis regardless of the number of employees in each firm.

Source: Lewin-VHI estimates using the Health Benefits Simulation Model (HBSM).

The Financial Impact of the Health Security Act

increase in spending of \$20 or more per year due to the fact that their insurance coverage is improved under the Act; and about 15% would experience spending increases of \$20 or more without improved coverage, notably younger persons, high income persons, and users of tobacco products. About 38 percent of families would see a change in spending of \$1,000 or more, one way or the other. About 80 percent of those who see an increase in spending of \$1,000 or more per family will have improved coverage.

There will be substantial shifts in spending among employers who provide insurance as well. About 53 percent of all employers who now provide insurance will see an annual decrease in spending of \$100 or more per worker, while about 43 percent of these employers will see an increase in spending \$100 or more per worker. However, about 23 percent of employers who spend more will be firms that currently cover less than 75 percent of their employees. Overall, about 53 percent of employers will see a change in spending -- either an increase or a decrease -- of \$1,000 or more per employee.

These wide shifts in household and employer health spending are the inevitable consequence of standardizing coverage and premium contribution requirements. More over, shifts of this type can be expected in any health reform initiative that seeks to redress what are arguably vast inequities in the current health care financing system.

I. Comparison with Administration Estimates

The primary difference between our estimates and those developed by the Administration are the premiums in the Regional Alliance. Our analysis indicates that premiums in the Regional Alliance would be about 17 percent higher than estimated by the Administration. Higher premiums lead to substantially higher levels of employer and household spending than are currently projected by the Administration under the Act. This, in turn, leads to larger premium subsidies. We estimate that net subsidy payments will be \$153 billion over the 1996 through 2000 period compared with the Administration estimate of \$116 billion (Table ES-3)

TABLE ES-3
COMPARISON OF ADMINISTRATION AND LEWIN-CHI ESTIMATES, 1995-2000
(IN BILLIONS)^a

	Administration	Lewin-VHI	Difference
SOURCE OF FUNDS			
Medicare Savings	\$124	\$124	\$0
Medicaid Savings	\$65	\$67	\$2
Federal Program Savings	\$40	\$27	(\$13)
Tobacco Tax Increase	\$65	\$66	\$1
Corporate Assessments (1% Payroll and Retiree)	\$35	\$45	\$10
Tax Effects of Mandate	\$23	(\$18)	(\$41)
Other Revenue Effects	\$37	\$31	(\$6)
TOTAL	\$389	\$342	(\$47)
USES OF FUNDS			
Subsidies	\$116	\$153	\$37
Contingency Cushion	\$45	\$0	(\$45)
Medicare Drug Benefit	\$66	\$59	(\$7)
Long-Term Care	\$65	\$65	\$0
Public Health/Administration	\$29	\$33	\$4
Self-Employed Tax Deduction	\$10	\$7	(\$3)
Deficit Reduction	\$58	\$25	(\$33)
TOTAL	\$389	\$342	(\$47)

Source: Presentation by Alice Rivlin and Lewin-VHI estimates.

In particular, the higher premium in our estimates leads us to different conclusions about the Plan's impact on employers. We show a net increase in employer spending through 2000 while the Administration projects a net reduction in employer health spending by 1999. Moreover, the Administration projects an increase in wages due to reduced employer spending with an associated increase in Federal income and payroll taxes of \$23 billion (Table ES-3). By contrast, our projected increase in employer spending under the Act is likely to result in offsetting reductions in wages which would be associated with a \$18 billion loss of Federal tax revenues due to the mandate.

For these reasons, we show a substantially smaller net reduction in the deficit under the Health Security Act than does the Administration. The Administration estimates that total deficit reduction over this period would be \$103 billion of which about \$45 billion is reserved as a cushion against unanticipated increases in spending under the Act. We estimate that this reserve cushion would be exceeded and that the net deficit reduction under the Act would be about \$25 billion over this period.

J. Caveats

Like most current health reform proposals, the President's health plan would implement a program that has never before been attempted on a broad scale in the United States. Consequently, there is little data on the likely outcome of such a program that can be used to estimate its impacts. Although the estimates in this paper are based upon the best data available at this time, they should be considered illustrative of potential impacts rather than point estimates of actual policy outcomes.

Moreover, this analysis does not consider some potentially important second order effects of the Health Security Act. For example, it does not consider the potential hidden costs associated with slowing the growth in health spending on technological developments and quality of care. The analysis does not take into account the potential impacts of reform on employment, international competitiveness, and general productivity growth. It also does not consider the potential impact that the early retiree provisions under the Act could have on retirement behavior and the economy over time. In particular, the study does not consider some of the potential social and economic benefits of health reform.

Our analysis indicates that the ultimate impact of the plan on the Federal deficit and employer spending is very sensitive to assumptions on the effectiveness of expenditure controls. Moreover, these estimates are very sensitive to employer and consumer behavioral responses under the new incentives created under the Act. Consequently, policy makers should recognize that any major health initiative is likely to require continued refinement in program financing over time.

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**LEWIN-VHI REPORT FINDS ADMINISTRATION COST ESTIMATES OVERLY
OPTIMISTIC BUT STILL REDUCES BUDGET DEFICIT**

WASHINGTON, D.C., December 8, 1993 - In the first complete independent analysis of the financing of President Clinton's Health Security Act, Lewin-VHI says the administration's plan to provide universal coverage will cost the country and the business sector more than advertised.

However, according to Lawrence S. Lewin, Chairman and CEO of Lewin-VHI, the internationally recognized health care policy and management consulting firm, the report "shows that the plan's financing structure works: it meets the President's requirement of providing universal coverage, and it does so without relying on an increase in broad-based income taxes.

"We think it is time first to focus on the validity of the assumptions underlying the plan, modify it as necessary, and then get on with the passage and implementation of a Health Care Reform Plan, says Lewin-VHI's President Robert J. Rubin, M.D., former Assistant Secretary for Planning and Evaluation in the Department of Health and Human Services in the early 1980s.

"The broader issue -- finding ways to control costs while expanding access and retaining high quality care -- should not be lost in a contest of predicting winners and losers," Rubin adds, noting that "any restructuring of this magnitude is bound to create gains for some, and losses for others."

2-2-2 LEWIN-VHI ESTIMATES ON HEALTH SECURITY ACT

This analysis came as a part of a press conference today at which Lewin-VHI announced publication of a detailed 196-page study "The Financial Impact of the Health Security Act" explaining the Plan's complex financing scheme. The report's findings and an analysis of its impact on providers of care, federal and state governments, employers, households, and the pharmaceutical and biotechnology industries will be presented at an all-day public meeting tomorrow, "Health Care Reform by the Numbers" at the Omni Shoreham, in Washington, DC. The purpose of releasing these independent estimates, is "to inject a measure of objectivity into the debate;" according to Lewin.

"These findings come at a time when there is growing skepticism about whether the President's plan could work. "This report", Lewin adds, "validates the logic of the plan's financing; it also clearly reveals how critical the underlying assumptions are". The Lewin-VHI study includes calculations showing the sensitivity of the bottom line to different behavioral assumptions. The "bottom line" here is the impact the plan's financing has on the federal budget deficit.

The calculations in this report rely on Lewin-VHI's Health Benefits Simulation Model (HBSM) the most commonly used model for estimating the impact of health care reform proposals.

The Lewin-VHI analysis also shows that American families as a group are the major beneficiaries under President Clinton's health care reform package, with employers, especially those not now providing insurance, bearing most of the cost of expanded national coverage.

"The 'magic' in the administration's plan, is community rating" says John Sheils, author of the study and an architect of Lewin-VHI's Health Benefits Simulation Model, created ten years ago to estimate the impacts of alternative health reform plans. Community rating is the phenomenon through which the costs of relatively sicker individuals are spread across a larger population. "This is quite simply a return to the way insurance used to work before insurers competed to avoid risk" Sheils said.

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3-3-3 LEWIN-VHI ESTIMATES ON HEALTH SECURITY ACT

Under the Health Security Act, all individuals in a given health plan would pay the same premium for their type of family, regardless of age or health status. By putting individuals with high utilization into the larger community pool, younger, healthier populations and their employers would share in the cost of their care. While community rating spreads these costs among employers and individuals, the federal government contributes subsidies to those employers and families unable to pay.

"Our analysis indicates that premiums in the Regional Alliances would be about 17 percent higher than those estimated by the administration and this influences much of the resulting financing," says Sheils. Lewin-VHI's estimate of higher premiums results in federal subsidies to employers and families of \$1.3 billion from 1996 through 2000, a figure that is \$37 billion higher than the Administration's five-year estimates.

Because of the higher premiums and the expansion of coverage to the 40 million uninsured, private employer health spending (after subsidies) will increase gradually from 1996 through 1998 and will be higher through the end of the century than under current policies. However, the growth rate of private employer spending is expected to decline after 1998.

The Act relies upon price competition among insurers as the primary means of cost containment. As a backstop measure, however, the plan places limits on the rate of growth in premiums to assure that the rate of growth in health spending is constrained.

"There is ample evidence that the kind of managed care the Health Security Act envisions can slow health care spending growth, but whether it will do so on a national scale and to the extent the President's plan requires, remains a bet, not a certainty," says Lewin. "On the other hand, premium caps, while a sure thing on paper, have to be achievable in practice, and will depend on the political will of elected officials and the voting public; so they are not a sure thing either."

The administration estimated a total deficit reduction between 1994 and 2000 of \$103.0 billion including \$45 billion reserved as a cushion against unanticipated increases in spending. The Lewin-VHI estimates predict that the reserve cushion will be exceeded and that the net deficit reduction will be about \$25 billion over the same period.

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4-4-4 LEWIN-VHI ESTIMATES ON HEALTH SECURITY ACT

In addition to detailing the financial effects of the plan, Lewin speakers at the all-day workshop will describe their analyses of the effects on key sectors of the health care economy. Highlights are:

States:

- States will spend less (\$12.4 billion in 1998) under HSA but will have the responsibility of supervising the Regional Alliances.
- Strong incentives to begin implementing alliances in 1996 will tax the capacity of most state governments.
- Alliance budgets will exceed the current state budget in a majority of states.

Local Governments

- Local governments will spend \$3.4 billion more in 1998 than they would under current policy, primarily due to the loss of DSH and the mandate to cover local workers.
- The HSA, although, addressing many of local governments historic needs, leaves gaps: many mental health and substance abuse services, prisoners and undocumented immigrants.

Providers of Care

- Hospital spending will be \$23.8 billion less in 1998, chiefly because of the impact of reduced utilization due to managed care and cuts in Medicare
- Physicians will see \$20 billion more in 1998, due to the impact of managed care and providing coverage for those currently uninsured, however, there will be distributive effects among physicians.

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5-5-5 LEWIN-VHI ESTIMATES ON HEALTH SECURITY ACT

- Physicians will face a ban on balance billing and other regulatory restraints if they remain in a fee for service setting.
- HSA will accelerate the current trend of provider integration.

Employers

- HSA's effect on employers is varied and complex. As a group they will pay more through the year 2000 than under current policy - a finding different than the Administration's.
- In general, firms that now offer insurance will see a reduction in spending while those that do not will see an increase.
- Manufacturing, transportation, communications, and utility companies will see a reduction in costs by 1998 while retail trade and service companies will see increases.

Pharmaceutical Industry

- The HSA expands access to pharmaceuticals and will result in a 6 percent increase in spending by 1998; there will however be an increase in regulation of drug prices especially new products.

Lewin-VHI, a subsidiary of Value health, Inc. is a health care consulting firm providing health policy, research and management consulting services to government agencies, health care providers, health industry suppliers, Insurers and Investors. It has offices in the Washington, D.C. and San Francisco bay areas.

Value Health, Inc. is a leading provider of specialty managed care benefit programs and health care information services.

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EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

FOR IMMEDIATE RELEASE
December 8, 1993

Contact: Barry Toiv
(202) 395-7254

STATEMENT BY DR. ALICE RIVLIN
DEPUTY DIRECTOR, OFFICE OF MANAGEMENT AND BUDGET

The Lewin-VHI study essentially verifies our estimates and the soundness of the financing of our proposal. The study confirms that the Health Security Act is fully financed and that it will reduce the deficit over the period from 1995-2000.

Our initial review of the Lewin-VHI study indicates that it substantially confirms our estimates of the financial impact of the Health Security Act. Because of slightly different assumptions, the study yields slightly different results. Despite these differences, the important point is that Lewin-VHI's estimates of the costs of the Health Security Act are roughly the same as the Administration's estimates; and their estimates of the savings that will be realized from the Health Security Act are roughly the same as the Administration's.

Lewin-VHI's estimates of the cost of the discounts for small, low-wage employers and for low-income workers are slightly lower than our estimates. Therefore, the Lewin-VHI analysis confirms that the entitlement caps we have placed in the Health Security Act are not likely to be exceeded.

We look forward to having an opportunity to review the Lewin-VHI study more thoroughly.

###

Note: The Lewin press release appears to contain an inadvertent factual error. The Lewin estimate of the discounts is \$153 billion; the Administration's estimate is \$161 billion, which is the amount of funding assumed in the entitlement caps in the Health Security Act. Therefore, contrary to a statement in the Lewin release, the study actually concludes that the cost of the discounts for individuals and businesses will not exceed the entitlement cap in the legislation.

THE WHITE HOUSE
Office of the Press Secretary

For Immediate Release

December 9, 1993

PRESS BRIEFING
BY
SECRETARY OF THE TREASURY LLOYD BENTSEN
DIRECTOR OF OMB LEON PANETTA

The Briefing Room

3:12 P.M. EST

SECRETARY BENTSEN: Good afternoon. We've only had a short time to study this Lewin report, but I must say it is most encouraging. There were a lot of people that said we couldn't have one of these, that we couldn't have universal coverage. But the Lewin report says we can. It says that we meet the overall objectives of the administration's plan. And not only that, that we do it without a broad-based tax and then in turn we make a contribution to the deficit.

I think it's encouraging -- you know, projections on a new program like of this with this scale, it's a challenge. We have plenty of experience in government making estimates of program --. But with this one we're looking at years into the future. So we had a number of agencies in the government work on it -- HCFA, Treasury, we had our estimators, we had our actuaries -- to try to be sure that we were right in this regard. And I think that they were very cautious in doing that. Our economists and our estimators at the Treasury Department looked at this one with a magnifying glass. We've had actuaries and estimators from the five largest accounting firms checking on the methodology -- to be right -- be sure we were right in that regard.

And the conclusions overall buttress each other, reaffirming my confidence in the estimating job that we've job. We're finding we agree on a number of points about the financing of health care reform. We agree that our plan is paid for. And we agree that there will be a deficit reduction. -- we don't come up with the same deficit number, but it's a major contribution on each on them insofar as cutting that deficit.

And I better point out that the estimates in this study of the subsidies that are required under the plan of the government spending, are less than we in the administration had reached, which I think shows how cautious and conservative we were in coming up with those numbers.

Americans deserve a comprehensive health care reform that covers everyone. And they expect the truth about what it will cost. And, once again, those estimates are buttressed by the Lewin Report.

DIRECTOR PANETTA: From the beginning of process of developing comprehensive health care plan, it's been our intent to produce a plan that was fully paid for and that had the most accurate estimates of costs available so that the American people could be confident that they could get universal coverage, and that they would get a plan that is fully paid for.

That has not been an easy process. As I indicated before, we began this year developing models that did not exist before in terms of determining a lot of the estimates with regards to cost. We believe we have the most accurate estimates, and we think that the Lewin Report in effect confirms that. We now have, I think, as a result of the Lewin Report -- and the people that are associated with that review and that analysis -- the same judgment that this plan is financially sound. As the Secretary has pointed out, I think, if there's anything that the American people were asking themselves when the President kept saying, "We can have comprehensive coverage of health care. We can have cost controls. We can reduce the deficit, and it doesn't demand a broad-based tax," we now have confirmation that, in effect, this can be accomplished. And I just would read for you a quote from the Lewin Report: This report shows, and I quote, "shows that the plan's financing structure works, it meets the President's requirement of providing universal coverage, and it does so without relying on an increase in broad-based income taxes."

Now, if I can, I would like to kind of point to where the areas of difference are, and generally how they arrive at their conclusions. This is about a 200-page report with about 80 pages of indexes, and we are still in the process of reviewing it. But to the best of our ability, these appear to be the principal differences with regards to the chart on my left that basically establishes what's in the President's plan in terms of cost, and the revenues that we will raise in order to cover those costs, and obviously the deficit reduction that would then result.

If I can draw your attention to the right side of the chart. On that chart there is a difference here with regards to the proposed premium -- they believe that the premium will be about 12 percent higher -- I think they say 17 -- but we estimate that using the right mathematics here it would be about a 12 percent increase in the premium. If you combine the \$117 billion and the \$44 billion, which is what we project on the premium cost plus the cushion, that number would be \$161 billion. The number that the Lewin report came out with is \$153 billion, so that even with the increase that they project in the premium -- we don't agree with that -- that it would involve that higher premium; we nevertheless are below the caps that we established with regards to the premium side.

On the Medicare drug benefit, we estimate the cost of that at about \$66 billion. They estimate the cost at less -- \$59 billion, which shows again that we tried to accept the most conservative judgments of the costs in these areas.

On long-term care they estimated the cost at \$62 billion -- we estimated the cost \$62 billion; their estimate is about \$65 billion -- but I have to tell you that they were working off a version that we provided earlier that involves a \$65 billion number. So, we think we're very close on the cost estimates with regards to long-term care.

The one area that we are not sure of what their estimates are, at least in a preliminary analysis, is on the public health part of this where we have public health and administration costs. We have estimated that at \$13 billion; and this is the one we're not sure how they come to their costs estimates and that's something we've got to continue to review.

On the revenue side, the Medicare savings are exactly alike. We have said \$124 billion on Medicare savings; their judgment is that we're right on the button with regards to our Medicare savings of \$124 billion. On Medicaid savings, we projected \$65 billion; their estimate is \$67 billion. So, they assume that we will achieve some additional savings, not much, but in these numbers, but nevertheless, they show that we will get about \$2 billion more in savings from Medicaid.

On the tobacco tax, our estimate on the tobacco tax is \$65 billion; theirs is \$66 billion. So, they're estimating, again, we're all in the right ballpark here -- about \$1 billion more on the tobacco tax.

On the corporate assessment which is part of this we really have not been able to determine what they estimate specifically with regards to revenues from the corporate assessment. On the federal savings, this is an area of difference -- we're assuming about \$40 billion in savings from various federal programs as a result of implementing this plan; they estimate \$27 billion. But I have to tell you that at least our sense of this is that the reason you're having less savings here is because of their higher premium estimate and what that then does with regards to savings, particularly with regards to federal employees.

Lastly, on other revenue effects on the \$86 billion that we estimate, we think there are differences here as well; and we are still in the process of trying to analyze specifically what those differences are. But when you add up where they're at in terms of revenues versus the cost, they arrive at a deficit number of \$25 billion as compared to our \$58 billion. Again, I think the point is this -- that they have essentially confirmed that we are well within the ballpark that we are working with here in terms of the estimates for this plan; and that the plan we have presented is indeed financially sound as we presented it.

What I hope we will do is be able as a result of this -- and I hope there will be continuing analyses that are done of these numbers. We have always said that these are our best estimates, and we hope that there are additional people who will look and analyze the numbers that we presented.

But we hope that in this process that the American people will derive as we have a degree of comfort here that we are in fact working with the right numbers in terms of the estimates and the costs; and that we can shift the debate here in the health care area to what exactly should be in the plan. I've often mentioned in the budget battle the credibility of our numbers was not questioned. It was a question of what should or should not be in the plan -- should there be additional revenue, should there be additional cuts. That's a fair debate. But we were right in terms of the numbers. And that's essentially the kind of debate we'd like to have on the health care plan. And we also hope that other plans will be subject to the same kind of review -- that Lewin will look at the other plans that are on Capitol Hill and make the same kind of analyses that he did with the President's plan.

I think the bottom line is that we derive a great deal of comfort as a result of this first analysis that we're on the right track when it comes to health care reform for this country.

Q How sensitive are these figures to the current interest rate environment -- I mean, you know, if the Fed ends up having to be on a tightening path as the economy picks up steam, how sensitive is this analysis to interest rates staying where they are now?

SECRETARY BENTSEN: First, let me say that I think you're going to see certainly long-term interest rates stay at the same relative level that they are now, because what we are seeing in the way of excess capacity and excess labor gives us some cushion in that regard. So I'm optimistic on it. Insofar as short-term rates, over a period of time, obviously they're going to raise some -- they're going to rise some. But I would not estimate that that would be anything major.

DIRECTOR PANETTA: Let me just -- there really is not that much that's included here that is interest rate-related in the sense of cost estimates with regards to either the drug benefits and others. I mean, obviously there would be some impact, particularly, I think, on the revenue that might flow in depending on obviously incomes and earnings and what have you. But other than that, I think that certainly in this interest rate climate, these numbers are right on track.

Q Can you tell us what the mechanism for the cushion is? How is that to be appropriated by Congress? And second, can you tell us how many businesses with how many employees do you expect -- be paying the corporate assessment?

DIRECTOR PANETTA: Do you have the number on the amount of businesses that would be paying the corporate assessment?

MR. THORPE: We don't have it with us. Again, the cushion in the --

DIRECTOR PANETTA: You want to come up here.

MR. THORPE: The cushion as we've shown it up here, as you'll know, in the capped entitlements that we have in the legislation that what we have under the premium discounts and the cushion is indistinguishable. So built into the capped entitlements are the \$161 billion in discounts. So they're really indistinguishable in terms of the legislation.

Q So would Congress appropriate \$44 billion or not?

MR. THORPE: (Ken Thorpe, Assistant Secretary, HHS) No -- yes, it is included -- absolutely -- is included within the yearly capped entitlements.

DIRECTOR PANETTA: You need to have the cushion appropriated so that we're protected with regard to the cap that's established in this program.

Q Lewin's numbers and yours assume you're going to bring health costs under control in par with your premium caps, Lewin predicts you'll get \$57 billion in reduced health spending by virtue of those caps in '98 alone. But there's a lot of doubt about whether you'll get those caps through Congress. How much confidence can people have that your numbers actually will hold up to the political realities facing you?

DIRECTOR PANETTA: Well, you know, as always. We present this plan as a comprehensive plan. And the cap is a part of that plan. And so we intend to go to the Congress and fight for that provision because we think it's very important to our ability to say to the American people that we're going to control costs. Now, obviously the debate in the Congress is going to take place and we're going to fight our way through the committees and on the floor. But the position of the administration is to fight to protect that because we think it's an important discipline when it comes to holding down costs.

Let me tell you something from just the budget perspective. And I'm right in the middle of working on the budgets right now. We are very much on track with regards to where the deficit is headed. We are now in a situation, having passed the budget plan, that we expect that we are going to not only meet but perhaps even exceed the deficit targets we're looking at. But it is absolutely essential if we're going to stay on track to pass health care reform. The only way you can keep us on track on the deficit so that we can bring that deficit hopefully below \$100 billion and eventually to balance is to pass cost controls on health care. And frankly the cap is a part of that process.

Q Director Panetta, on the deficit issue, the mayors were here this morning, they told us that the President told them that crime is now the number one domestic agenda issue. They have asked for huge increases in crime spending. Are you going to be able to do that and still meet your deficit targets?

DIRECTOR PANETTA: We are operating under a hard freeze cap. That basically means that what we spent in '93 is what we're going to spend for the next five years in the federal government. That means that if there are areas in which we are going to increase spending, we're going to have to find savings elsewhere. And that's the process we're going through. On crime, essentially what the Congress is doing and I think what the President envisions is that whatever we commit to pay for the war against crime in this country is going to come within the caps established by the Congress. And we will have to find savings elsewhere in order to pay for that priority.

Q -- said a few minutes ago that you're on track in terms of the deficit and you may even exceed your target. Now, as I remember for '94 your deficit number in your last forecast was like 260, and the '93 figure came in much lower than you had thought. Can you give us -- I realize you can't give us an exact number -- can you give us some idea of what the '94 deficit -- what your general ballpark estimate is now for the '94 deficit?

DIRECTOR PANETTA: Right now, we think we'll be below the mid-session projection on the deficit. I can't tell you how much. We're still getting the projections coming in. But by '98 we think that frankly instead of looking at \$180 billion deficit, it'll be more like \$150 billion.

Q The President talks a lot about personal responsibility in terms of welfare reform. There's a lot of talk on the Hill about personal responsibilities when it comes to health care reform and placing that requirement or the obligation up to the individual to obtain the health insurance. Would the President accept a plan if it had universal coverage and comprehensive package of benefits if the mandate is up to the individual rather than the employer to obtain other --

SECRETARY BENTSEN: I don't believe under those conditions you'd get universal coverage. So we look at the practicality of the application -- what would be forthcoming. And I think the employer mandate is a prerequisite.

Q So you think the Chafee approach would be unacceptable to you?

SECRETARY BENTSEN: I beg your pardon?

Q Does that mean then the Chafee approach would be unacceptable to you because it leaves it up to the individual --

SECRETARY BENTSEN: Well, I've already told you what I thought the administration's point of view is, and we feel that quite strongly, that we think it has to be an employer mandate to be able to bring about universal coverage. And I think these things that we've seen in the way of estimates are fortifying our position as to be able to accomplish it without any broad-based tax and end up paying for it in full with some leftover to curtail the deficit.

Q Do you think you are losing a lot of ground lately that there's has been sort of a backsliding in support for the plan in terms of the AMA and the public at large?

SECRETARY BENTSEN: I heard that same talk on the budget and on NAFTA. No, I think we're going to put together one where we accomplish it next year, and we'll get a package through that is satisfactory to the administration.

MS. MYERS: Thank you.

END 3:30 P.M. EST

Health Plan Funding Passes Master

Independent Group Says Clinton Proposal Is Financially Sound

By Spencer Rich
Washington Post Staff Writer

An independent research group that included officials of the Reagan administration has concluded that the proposed funding system for President Clinton's national health plan is basically sound.

"If the question is whether they can finance this program with the revenues they will get under their answer is yes, and they will still end up with \$25 billion for budgetary deficit reduction," said Lawrence S. Lewin, chairman of Lewin-VHI, which conducted the study released yesterday. "It meets the president's requirement of providing universal coverage, and it does so without relying on an increase in broad-based income taxes."

"Our funding estimates are in the same ballpark as theirs," said Robert J. Rubin, assistant secretary of labor and human services in the Reagan administration and now president of Lewin-VHI, which conducts studies to determine the costs of various health programs. Don Peck, former top aide to Reagan's Office of Management and Budget Director David A. Stockman, also worked on the report.

The Clinton administration greeted the study with delight. For months it has been battered by assertions from congressional Republicans, such as Rep. Thomas J. Bliley Jr. (Va.), and from numerous groups representing businesses and providers of medical services that the financing mechanisms for the president's health plan could result in severe underfunding and perhaps a need for new taxes and premiums far beyond what the White House has estimated.

Even some Democrats who favor the plan, including Rep. Henry A. Waxman (Calif.), have questioned some of the numbers.

Alice M. Rivlin, deputy director of the Office of Management and Budget, said, "The Lewin-VHI study essentially verifies our estimates of the soundness of the financing for our proposal," confirming that the plan "will reduce the deficit over the period from 1995 to 2000."

In addition to its broad finding that the "financing structure works," the study also found that:

- In 1998, health insurance premiums under the president's plan in 1998, used as an example year, would be about 17 percent higher than the administration estimated, requiring more federal premium subsidies for businesses and poor individuals.

- In 1998, employers (primarily firms that do not now insure their workers) would pay a net of \$28.9 billion more for health care than under current law because of the requirement that they provide insurance to their workers, but households would pay a net of \$26.5 billion less because the government and employers would be picking up much more of their costs. The extra payments by employers would gradually drop as cost controls took effect.

- The plan's cost controls eventu-

ally would slow the growth of health spending. By 2000, it would account for 18 percent of gross domestic product instead of the 18.7 percent figure expected under current conditions, a saving of \$57 billion.

The study, conducted primarily by Lewin-VHI vice president John Sheils, was financed by the firm itself, Lewin said.

Lewin, Rubin and Sheils all emphasized strongly that no study of an untested new system can be taken as an absolute prediction or guarantee that the plan will work as envisioned. Lewin said the findings are based on their best estimates and predicated on the assumption, which could be optimistic, that the states, Congress, the proposed national health board and all others will have "the political will" to adopt and enforce difficult aspects of the president's plan. That would include requiring all employers to insure their workers and limiting insurance premium increases.

Looking at the federal portion of the funding for the plan, the study said the White House had claimed that it would raise \$389 billion in federal funds from 1995 to 2000 to cover \$286 billion in federal costs for the basic plan plus \$103 billion for contingencies and deficit reduc-

tion. Sheils said the basic plan would actually cost the federal government \$317 billion, not \$286 billion, and the proposed funding would raise \$342 billion. That would be enough to cover the \$317 billion cost with \$25 billion left over for deficit reduction—but nothing for contingencies, the study said.

Sheils concluded that in 1998 the average annual premium for an individual would be \$2,732; for a couple, \$5,464; and for a two-parent family, \$5,975.

In a separate development yesterday, presidential pollster Stan Greenberg, appearing on an American Enterprise Institute panel, said the administration had considered proposing a value added tax (VAT) to pay for the health care reform program but found virtually no public support for it in polls conducted on the issue.

Greenberg said the administration looked at the VAT as an alternative to mandating employers to pay 80 percent of their employees' health insurance costs. He said it was one of at least two instances where polling had been used to determine public attitudes toward particular tax policies.

Staff writer Dan Balz contributed to this report.

THE WASHINGTON POST

THURSDAY, DECEMBER 9, 1993

Health-Plan Cost Outlook Is Too Rosy, But Basic Financing Works, Firm Says

By HILARY STOUT

Staff Reporter of THE WALL STREET JOURNAL

WASHINGTON—A respected health-research firm said the Clinton health-care plan will cost employers and individuals more than the White House projects, but it said the administration's overall financing proposals are sound.

The company, Lewin-VHI, a unit of Value Health Inc., released a 186-page analysis of President Clinton's proposal to guarantee health coverage to all Americans. It concluded that the White House can successfully pay for its plan through its strategy of wringing savings from current public health programs, raising the excise tax on cigarettes and other tobacco products and holding down medical costs through competition and controls on health insurance premiums.

"The plan's financing structure works," said Lawrence Lewin, chairman and chief executive of Lewin-VHI. "It meets the president's requirement of providing universal coverage, and it does so without relying on an increase in broad-based income taxes."

But Lewin-VHI disagreed with the White House on what premiums would be required to pay for the health benefits it proposes. The administration projects that the average premium once the system is fully phased in would be \$2,388 for an individual; the company's estimate is \$2,732. The White House projects the premium for a two-parent family with children would be \$5,388; Lewin-VHI puts it at \$5,975.

As a result of the higher premium projections, Lewin-VHI estimates that the subsidies proposed for businesses and low-income individuals would cost \$37 billion more during the first five years of the plan than the administration says — \$153 billion instead of the White House estimate of \$116 billion.

However, the legislation that the president submitted to Congress adds a \$45 billion cushion to the overall subsidy figure. Counting that, the Lewin-VHI subsidy estimates come in \$8 billion lower than the White House projections.

Lewin-VHI, based in Fairfax, Va., is one of the few organizations outside the government with the computer models needed to analyze complex health-care legislation. Administration officials, members of Congress, and numerous public interest groups respect the firm, and believe its evaluations to be credible.

White House officials, who had been nervous about the Lewin-VHI review, said they were pleased by the conclusions. "To have someone come out and confirm the fact that our estimate of the [subsidies] are conservative and that we get substantial deficit reduction is, I think, really a critical finding," said Kenneth Thorpe, the Department of Health and Human Services economist who oversaw the administration's number-crunching operation.

The White House predicts the savings in public health spending through the year 2000 will result in a \$58 billion reduction in

the federal budget deficit. Lewin-VHI says the shrinkage will be \$25 billion.

The administration's financing estimates have been criticized by lawmakers in both parties. And despite the report's conclusions, Lewin-VHI officials expressed some doubt at a news conference about the feasibility of some of the administration's savings projections. "There is a lot of potential fat in the system. Whether you can get it out this way, no one knows," said Robert Rubin, Lewin-VHI's president. "I've been on record saying that I think it will be difficult, but not necessarily undoable."

The report contains a number of other estimates that could cause political difficulties for the White House. For example, the administration has been saying that overall employer spending on health won't rise under the Clinton plan, even though the White House is proposing to require all firms to contribute to paying their workers' health premiums. Lewin-VHI estimates that the total cost to employers in 1998, the first year the Clinton plan would be fully phased in, would be \$29.3 billion higher than under the current system. Almost all of the increase, however, would come from firms that currently don't insure their workers.

Lewin-VHI officials said the company analyzed the Clinton plan on its own initiative, and paid for the project itself. The undertaking wasn't sponsored by "any government agency or private group," Mr. Lewin said.

Encouraging checkup for Clinton health plan

But study also disputes some administration figures

By Judi Hasson
USA TODAY

The White House, which has been criticized for its health-reform arithmetic, was relieved Wednesday to get a stamp of approval from an independent consulting firm.

Skeptics, many of whom support competing health bills in Congress, have charged that the administration's revenue and cost projections don't add up. They also argue that the White House expects unrealistic savings in the Medicare and Medicaid programs and underestimates the cost of providing benefits to every American.

But a study by Lewin-VHI, a health policy research firm, says some administration calculations are on target.

"There's a lot of potential fat in the system which you can get out," said Lawrence Lewin, the firm's chairman.

But the study — the first comprehensive outside analysis of the Clinton plan — also disagrees with some White House figures.

The study found that:
▶ The average cost of premiums would be 17% higher

than the White House is projecting. Administration officials dispute that conclusion.

▶ There would be a deficit reduction of \$28 billion, about half the administration's \$58 billion projection.

▶ It would take until 2002 before employers save money. The administration says employers' health insurance costs would decline before 2000.

▶ It would cost about \$153 billion in subsidies between 1996 and 2000 to help small businesses insure low-wage workers. The administration estimates spending \$116 billion in subsidies.

Even so, the White House was pleased.

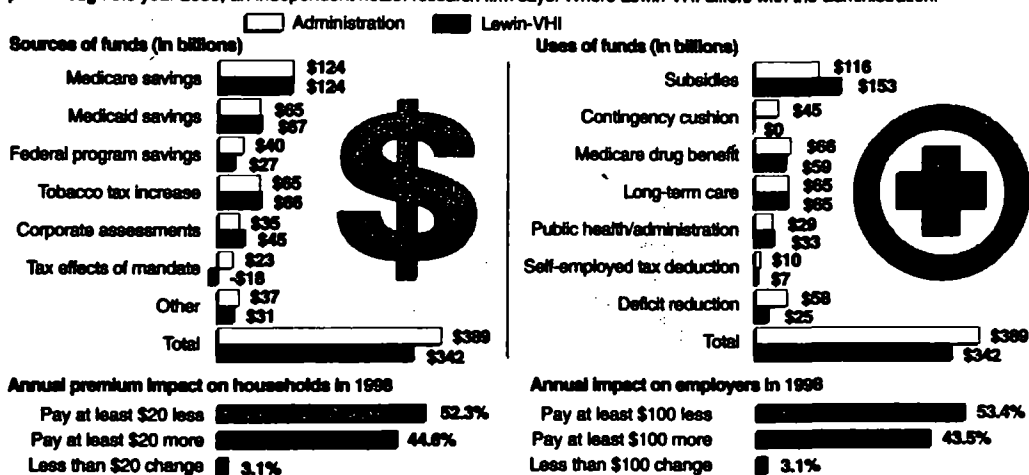
"Because of slightly different assumptions, the study yields slightly different results," said deputy budget director Alice Rivlin.

"The important point is that Lewin-VHI's estimates of the costs... are roughly the same as the administration's estimates," she said.

White House health adviser Kenneth Thorpe said the administration would release its own financial analysis of the plan today or Friday.

A comparison of health-care costs under the Clinton plan

The Clinton health-care reform plan needs insurance premiums 17% higher than the White House has estimated to pay for the plan through the year 2000, an independent health research firm says. Where Lewin-VHI differs with the administration:



By Nick Galtieris, USA TODAY

The Lewin study concluded that most families would pay less for medical care — including insurance premiums plus all out-of-pocket expenses — under Clinton's plan.

Only 7.1% — those with household incomes of more than \$100,000 — would pay more, \$281 a year. However, other consumers could pay

more if they chose optional higher-cost health plans.

Families with annual incomes below \$10,000 would save an average \$742 a year, the report said.

Others whose total health spending would go down, according to the report: those age 55 to 64, who would save \$782 per family, largely because the

federal government would pick up 80% of premium costs for early retirees.

The report found \$20 billion more would be spent in 1998 on visits to doctors' offices, because with insurance, more people would go to doctors, including poor people who now rely on emergency room care. Other findings:

▶ Employers that currently do not insure workers would pay \$161 a month per worker in 1998 to provide insurance.

▶ The plan would save \$15 billion by encouraging more people to join health maintenance organizations and other forms of managed care.

Health plan passes reality check

Cost estimates are off, but workable

BY R.A. ZALDIVAR
Free Press Washington Staff

WASHINGTON — President Bill Clinton's health care plan would cost less on more than the administration projects but still could provide health insurance for all without broad new taxes, according to a major study released Wednesday by independent analysts.

In what amounts to a reality check of the White House plan, the health care research and consulting firm of Lewis-VRH found that the administra-

tion underestimated the cost of its benefits package.

About 45 percent of households would pay more for health care under Clinton's plan than they would otherwise, while the remainder would pay less or about the same.

The report found that older Americans would save the most from the Clinton plan, while costs for some young adults would go up.

But, to the relief of administration officials, the Lewis report concluded that the bill would accomplish Clinton's

central goal: universal coverage without still new taxes. That's because Clinton's planners had allowed for a \$45-billion cushion in case their cost estimates were off.

"The plan's financing structure works," said Lawrence Lewis, chairman of the Washington, D.C.-area company, whose expertise in health care economics has been widely used by all sides in the reform debate.

"We're really happy with this," said White House spokesman Bob Boorstin. "Above all, it confirms that the act is fully financed, that the numbers are real, and that it will reduce the deficit."

See HEALTH CARE, Page 9A

•DETROIT FREE PRESS

12/9/93

Health plan passes independent review

Costs are off, but goal reachable, says firm

HEALTH CARE, from Page 1A

Nonetheless, the report is likely to provide fodder for both sides in the debate. Among its main conclusions:

- The White House significantly low-balled the cost of Clinton's comprehensive benefits package. Lewin estimates the package will cost \$2,732 for individuals and \$5,975 for a two-parent family in 1998 — the first year during which all Americans would be covered. The administration has estimated the benefits will cost \$2,388 for an individual and \$5,388 for a two-parent family.
- About 26 percent of American households would pay at least \$500 more for health care in 1998 under the Clinton plan than they would otherwise. Another 18 percent would pay at least \$100 more. But 34 percent of households would save at least \$500, while 14 percent would save at least \$100. Most of those paying more would be getting better benefits than they now have.

- The White House says less than 40 percent of insured individuals would pay higher premiums, but has offered no figure comparable to Lewin's for how the plan would affect households.
- Employers would not start saving money on health care costs until 2002, versus 1998 in administration projections. About 44 percent of companies that now provide coverage would pay at least \$100 more per employee in 1998; 53 percent would pay at least \$100 less, and 3 percent would see virtually no change. Clinton's plan requires all employers to provide coverage.

- White House projections that Clinton's bill cuts the deficit by \$58 billion between 1995 and 2000 are too optimistic. The Lewin report estimated the bill would reduce the deficit by \$25 billion, but warned that even slight changes in the rate of increase of health costs could wipe out any gains and result in more red ink for the government.

Lewin-VHI prepared the report independently, not for a particular client.

Marilyn Moon, a health policy specialist with the nonpartisan Urban Institute in Washington, said Lewin is one of the few research organizations with the capacity to estimate health care costs for society as a whole.

"I don't view them as trying to stack the deck — they have good

credibility out there," said Moon. "They seem pretty consistent with the administration, but more pessimistic."

As far as impact on individuals, the Lewin report concluded that older people stand to gain the most from the Clinton plan, particularly the 55-64 age group. Clinton's proposal to pay 80 percent of the health insurance costs of early retirees would save the average household headed by a person in that age group \$781 in 1998.

The average household headed by a person over 65 years old would save \$488, largely due to new Medicare coverage of outpatient prescriptions.

Younger people would save much less, and many would pay more. Premiums for younger, healthier people who now get discounts would increase as the nation shifts to a system of "community rating," where everybody in a given area pays the same for health coverage. The average household headed by a person between 25 and 34 would save only \$199.

Among households, the biggest losers would be those with incomes of more than \$100,000. On average, they would pay \$281 more a year. This is due to the repeal of a health care tax break for working-age people and higher premiums for well-to-do Medicare beneficiaries.

As for businesses, the Lewin report concluded that the brunt of Clinton's requirement that all employers provide coverage would fall on retail, service and construction industries.

State governments would spend less because of changes in the Medicaid program for the poor, but city governments would face higher costs because Clinton's plan would eliminate some federal payments to hospitals.

a/a

Outside Analysts: Clinton Health Plan Can Avoid Broad Tax Hike

Eds: This also moved on general news wires.

By CHRISTOPHER CONNELL= Associated Press Writer=

WASHINGTON (AP) An independent analysis of the Clinton health plan concludes that it can cover everybody without a broad-based tax increase and still reduce the federal deficit.

But the deficit reduction would be much less than the White House forecast and the insurance premiums Americans pay would have to be higher, according to the 196-page study issued Wednesday by the health consulting firm of Lewin-VHI.

The White House was pleased, even though the study disputed some administration calculations.

It "essentially verifies our estimates and the soundness of the financing of our proposal," said deputy budget director Alice Rivlin. It "confirms that the Health Security Act is fully financed and ... will reduce the deficit."

The report by the respected Fairfax, Va., firm estimated that Clinton's health reforms could cut families' medical bills including premiums and out-of-pocket costs by \$26 billion in 1998.

At the same time, businesses would have to spend \$29 billion more for health care, with virtually all of the extra money coming from companies that now fail to insure their workers.

Lawrence S. Lewin, chairman of the Fairfax, Va., firm said, "The bad news is that there isn't nearly as much cushion as they said there would be. The good news is that they still haven't crossed the line into requiring new taxes."

The study estimated that premiums in 1998 would have to be:

\$2,732 for individuals.

\$5,464 for couples.

\$5,172 for one-parent families.

\$5,975 for two-parent families.

Lewin said that is 17 percent higher than the administration is projecting.

Kenneth Thorpe, a deputy assistant secretary of health, disputed that and said the gap was only 12 percent.

The Lewin study estimated Clinton's proposal would reduce the deficit between now and the year 2000 by \$25 billion, not the \$58 billion the White House estimated.

But assuming that Clinton's proposed caps on health insurance premiums work, "then the rest of it plays out," said Lewin. "There is no smoke and mirrors here."

"We think their estimates have been overly optimistic, but they still achieve deficit reduction," he added.

Clinton would require all employers to help pay for health insurance, and levy a 1 percent tax on big corporations that self-insure their workers. Everyone else would get their coverage through giant new insurance-purchasing pools.

The White House is counting on big savings in Medicare and other health spending. Its only major tax hike would be on tobacco.

"It confirms what we've said all along: Our numbers are on the conservative side," said Thorpe.

He noted that the Lewin team figured premium subsidies for small businesses would cost \$153 billion over six years, or \$8 billion less than the White House estimated.

The study, "The Financial Impact of the Health Security Act," also concluded:

Employers will spend more on health care through 2000, but their costs will climb at a slower rate.

The changes will trigger an \$18 billion loss in income and payroll taxes, not the \$23 billion increase the White House predicted.

Total health spending would grow from \$912 billion in 1993 to just under \$1.4 trillion in 1998. Without reform, the health bill would be \$600 million higher in 1998.

The plan would save \$15 billion by encouraging more people to join health maintenance organizations and other forms of managed care.

It said that in 1998 alone:

The premium cap would save almost \$57 billion.

Families would pay \$26.5 billion less.

Businesses would pay \$29 billion more.

Federal health spending would climb by \$6 billion.

State governments would pay \$12.4 billion less in health costs.

Local governments would pay \$3.4 billion more.

Hospital spending would be almost \$24 billion less.

Physicians would get \$20 billion more in revenues.

ESTIMATING THE IMPACT OF HEALTH REFORM ON FEDERAL RECEIPTS

Executive Summary

The Treasury Department's Office of Tax Analysis (OTA) is responsible for preparing revenue estimates of proposals which affect Federal receipts. In general, OTA analyzes legislative proposals that change the Internal Revenue Code. OTA also analyzes the effects of certain legislative changes which do not amend the Internal Revenue Code but nonetheless affect Federal receipts. For example, changes in the laws concerning employer provision of certain fringe benefits can affect receipts because of the favorable tax status of such benefits.

The tax code also provides preferential treatment for certain types of health insurance expenditures. Health insurance contributions receive preferential tax treatment under several different provisions. Employer contributions for health insurance are deductible as a business expense by the employer and are excluded from the income of employees. Through their employers, some employees may have the option of contributing to tax-preferred cafeteria plans, enabling them to pay for their portion of health costs with pre-tax dollars. Self-employed individuals can deduct 25 percent of health insurance costs from adjusted gross income. Taxpayers can also deduct qualifying medical expenses which exceed 7.5 percent of their adjusted gross income. As a consequence, changes in the financing of health insurance will have implications for Federal receipts.

Estimating the effects of health reform on Federal receipts has required a cooperative effort among many agencies. The undertaking has demanded a broad understanding of the provisions contained in the proposal. Estimating the revenue impact of the proposal has required many data inputs from other Federal agencies involved in this process. To maintain consistency while estimating the costs of the health reform plan, the estimates of the revenue impact of the plan rely on certain inputs from other Federal agencies involved in this process. Because of the interaction among the provisions, a change in one or two of the basic underlying policy parameters could trigger significant changes in the revenue estimates.

The health reform plan contains many non-tax provisions which may affect Federal receipts by changing the financing of health care. Each of these provisions may have very different effects on revenues, but in combination the Administration's plan results in a net increase in Federal receipts over the budget period. An alternative plan with similar features could yield very different revenue results, even if it differed from the Administration's plan in only a few key non-tax aspects.

This technical note provides background as to the methods and assumptions underlying Treasury's estimates of the impact of health reform on Federal receipts. In preparing these estimates, Treasury followed long-standing estimating conventions accepted by both Administration and Congressional agencies responsible for producing estimates of the budgetary impact of legislative proposals. In analyzing the revenue impact of non-tax changes in the financing of health insurance, Treasury has used the same methodology and models which are used to estimate the effects of changes in Internal Revenue Code provisions on receipts.

Individual Tax Model

The Individual Tax Model (ITM) is one of the most powerful tools developed by OTA to aid in estimating changes in Federal receipts. The ITM is a large microdata simulation model. The microdata aspect of the model refers to the fact that it contains data on the income, deductions, health expenditures, and other characteristics of individual tax filing units and families. The model can simulate the taxes paid under both current law and proposed changes in law.

Professional economists in OTA construct, maintain, and utilize the ITM. OTA economists share a broad background in applied microeconomics, particularly in public finance. In addition, OTA economists are also specialists in other fields, such as econometrics, health economics, labor economics, statistics, and computer programming. These skills are used to develop the inputs to the model and for examining its outputs.

Interactions with Other Agencies with Interests in Tax and Health Policy Questions

OTA economists communicate regularly with their counterparts at the Joint Committee on Taxation (JCT) and the Congressional Budget Office (CBO), who also use large microsimulation models. Such contacts are useful both for identifying differences among the models as well as for developing consensus among the agencies responsible for analyzing the receipts effects of proposals.

In the health area, OTA staff maintains regular contact with numerous specialists. Members of OTA staff routinely discuss health modeling issues with staff from several agencies in the Department of Health and Human Services, including the Agency for Health Care Planning and Research (AHCPR), the Office of the Assistant Secretary of Planning and Evaluation (ASPE), and the Health Care Financing Administration (HCFA). In addition, OTA consults with health policy staff at the Council of Economic Advisers (CEA), the Office of Management and Budget (OMB), and the CBO.

OTA's extensive contacts with the staffs of other government agencies and outside experts provide additional access to data, research, and other techniques which are generally useful for model development. In many cases, these contacts are long-standing.

Description of the Individual Tax Model¹

Data: The current version of the ITM was constructed from a sample of 110,000 individual

¹ For a more detailed discussion of the Individual Tax Model, see James Cilke and Roy A. Wyscarver, The Treasury Individual Income Tax Simulation Model. Department of the Treasury, Office of Tax Analysis, March 1990.

income tax returns filed in 1989. The data base is a stratified probability sample of tax returns prepared by the Internal Revenue Service's Statistics of Income (SOI) Division.² This is the same sample employed by the SOI to produce the tabulations published in the Statistics of Income - 1989 Individual Income Tax Returns. When weighted, these data represent the total population of taxpayers in the United States.

Tax returns contain extensive information on the components of taxable income. In addition, tax returns provide information about taxpayers' marital status and family size. However, tax returns do not contain information on other demographic characteristics, on non-taxable forms of income such as welfare benefits or earnings on pension and other retirement savings, or on expenditures made by the taxpayer. Nor do tax returns provide any information on families outside the tax system.³ More comprehensive information than is provided on tax returns is needed to analyze the impact of proposals which extend the current income tax base and to analyze payroll, excise and other taxes.

To add more information, the SOI tax return data are first matched to age data from Social Security records and then statistically merged with records from the Current Population Survey (CPS) conducted annually by the Bureau of the Census. The records in the ITM are grouped into family units as well as income tax return units, and are weighted to represent the entire filing population and noninstitutionized nonfiling population. The SOI file is also statistically merged with records from the Bureau of Labor Statistics' Consumer Expenditure Survey. In addition, imputations of other critical income, asset, expenditure, employment, and demographic measures are made using a variety of sources (e.g., the Federal Reserve Board's Survey of Consumer Finances).

The data sources described above contain only limited information on expenditures on health care. From tax returns, information is available on the amount of health insurance purchased by self-employed persons who claim a 25 percent deduction. Tax returns also contain information on certain health expenditures, but only for those filers who itemize deductions and whose expenditures exceed 7.5 percent of their adjusted gross income. The Current Population Survey provides information on the insured status of individuals, including whether the insurance is provided through private or public sources. Lacking from these surveys is information on a family's total expenditures (including any employer contributions) on health insurance, characteristics of their insurance policy, and the health status of family members.

² Under Section 6103 of the Internal Revenue Code, OTA and JCT have access to tax return data, including the complete SOI file. A public-use computer tape file is available to other analysts, but it has fewer data items and taxpayer records and does not contain information which might violate the confidentiality of taxpayers. In particular, the public use file blurs information on high-income taxpayers.

³ Nonfilers are predominantly low-income persons who do not have an income tax liability and do not file a return to claim a refund.

To supplement these data sources, OTA statistically matched the data from the 1987 National Medical Expenditure Survey (NMES) to the ITM. The NMES is an extensive survey of approximately 14,000 households representing the civilian, noninstitutionalized population of the United States. It was conducted under the auspices of the Department of Health and Human Services' Agency for Health Care Planning and Research (AHCPR). The 1987 survey updates and expands previous surveys conducted in 1977 and 1980. The surveys collected information about participants' utilization and expenditures for health services, health insurance coverage, health status, and employment and income. Data from the household survey are supplemented by information from medical providers, employers, and insurers.

Extrapolation: The complete data file is then extrapolated to future years based on the economic forecasts used in the Budget.⁴ The extrapolation is done in two stages. The first stage adjusts for anticipated economic growth and inflation. This is accomplished by multiplying the various income, deduction, and credit items on each return by forecasts based on per-capita growth rates estimated from the economic forecasts. In the second stage, the weights assigned to the records in the file are changed to hit separately determined targets for key variables, including the size distribution of adjusted gross income.

The growth rates for health data are generally based on projections contained in the Federal Budget or the National Health Accounts. Where relevant, the targets reflect significant changes in participation or expenditures since 1987 (the base year for the NMES) or 1989 (the base year for the CPS). For example, a major expansion in Medicaid will affect participation rates during the mid-nineties. To ensure consistency with the Administration's Budget estimates, the Health Care Financing Administration's projections for persons insured by Medicaid are used to estimate targets in the extrapolation of these items in the ITM.

Tax Calculator: Using the extrapolated files, the tax laws for each year in the Budget period are simulated. In combination, these simulation programs are referred to as the "tax calculator" or simply, the "calculator." The calculator takes information from each potential tax filing unit in the data file, and using a set of specified tax parameters, computes that unit's Federal individual income tax liability under the proposed change in law.

Two basic revenue estimating assumptions are embedded in the calculator for computing tax liabilities. First, all filers are assumed to choose tax options which minimize their tax liabilities. Second, variables such as the level and distribution of total pre-tax income or total expenditures are held constant when simulating a tax policy change.

The calculator computes the values of a number of variables that are endogenous to the

⁴ At the time of the release of the Administration's health reform plan, the estimates were based on the Administration's economic assumptions contained in the 1993 mid-session review. The economic assumptions were extended through the year 2000 by OMB for purposes of determining the longer-term budgetary impact of health reform.

model -- that is, these are tax variables, in addition to liabilities, which may be affected by a proposal and which, in turn, can affect the calculation of tax liabilities. In general, the ITM can trace through most of the interactions between any income source and the various provisions of the Internal Revenue Code.

Appropriate behavioral responses have been incorporated into the tax model. In addition, as will be discussed further below, off-model adjustments are often made by the analysts to incorporate other anticipated behavioral changes in response to a proposed tax change.

Uses and Limitations of Model Output

As noted above, the ITM is a powerful tool which enables OTA economists to better analyze the effects of various proposals. There are several important distinctions, however, between the output of the tax model and the final analyses prepared by OTA.

First, even in the simplest case, output from the ITM does not go unexamined. Output is subject to a reality check. Users of the ITM check carefully the results to determine if they appear reasonable. For example, users may compare the extrapolation of a particular variable with data which has become available since the initial construction of the tax model. Such information may include data from more recent samples of tax returns (e.g., the 1991 SOI sample of tax returns), other government organizations (e.g., the Bureau of Labor Statistics' Surveys of Employee Benefits; the Census Department's Survey of Income and Program Participation), trade associations (e.g., surveys conducted by the Health Insurance Association of America), and independent consulting organizations.

Second, the ITM is best utilized to analyze the effects of changes in the tax code that affect broad groups of taxpayers and involve current law tax rules. The tax model cannot be relied upon exclusively to estimate changes in the tax code which affect narrow populations or introduce new income tax rules. In these instances, OTA economists may rely on "spreadsheet" models to produce estimates of tax changes. Often, these spreadsheet models are, themselves, quite extensive and sophisticated. In many cases, information from the ITM (e.g., the marginal tax rate faced by a comparable group of taxpayers) may be used as input into these spreadsheet models. The ITM is also not used to analyze proposals affecting tax units other than individuals. For these purposes, OTA maintains several other tax models, including a corporate model, a depreciation model, and an estate model.

Third, subject to certain budget estimating conventions, estimates of the revenue effects of tax changes include assumptions about changes in taxpayers' behavior induced by changes in tax policy. Given the set of macroeconomic assumptions used to prepare the Budget, major GDP components -- such as real and nominal GDP -- are assumed to be fixed for purposes of estimating the deficit impact of a proposed change in legislation. Thus, for revenue estimates, behavioral effects are constrained by this "fixed GDP" assumption. Behavioral assumptions which affect the composition of GDP, but not its level, are integral to the revenue estimates.

Off-model adjustments are generally necessary to account for the full range of potential behavioral effects.

Fixed GDP Assumption

The "fixed GDP" budget estimating convention is a long standing rule and is followed by the Office of Management and Budget, Treasury, and all other Executive Branch agencies. The Congressional Budget Office (CBO) and the Joint Committee on Taxation (JCT) follow a similar convention, using the economic assumptions contained in CBO's budget analyses. The "fixed GDP" assumption allows policymakers to view the effects of proposed change in law on the deficit, as forecasted in the most recent Budget.⁵ Without such a convention, dozens of analysts in each agency could derive their own independent forecast of GDP each time they estimated the deficit impact of a proposed change in legislation.⁶

As a consequence of the fixed GDP assumption, Treasury, CBO, and JCT assume that total employee compensation remains unchanged in response to a requirement that employers provide a new fringe benefit to their workers. This identity is derived from the Census Bureau's National Income Accounts (NIA). Under these assumptions, if employer contributions for health insurance increase, then other forms of labor income -- wages or other fringe benefits - must decline in order for GDP to remain constant.⁷ However, if wages and salaries decline, income taxes and employment taxes must decline as well. This effect is sometimes referred to as the "income offset."⁸

⁵ Under the Budget Enforcement Act of 1990, the estimates of legislative proposals are based on the economic assumptions contained in the President's Budget. At the time of the introduction of the Administration's health reform bill in the fall of 1993, it did not seem likely that the legislative action would be completed by the end of the year. As a consequence, there was an Administration-wide decision to use the recent economic assumptions contained in the Mid-session review.

⁶ The fixed GDP assumption is discussed in detail in Howard W. Nester, "A Guide to Interpreting the Dynamic Elements of Revenue Estimates," Compendium of Tax Research 1987, C. Eugene Steuerle and Thomas Neubig, eds. Washington, D.C.: Government Financing Office, 1987, pp. 13 - 41.

⁷ Some benefits -- such as employer contributions for social insurance -- are linked by law to wages and thus change as wages change.

⁸ For a discussion of the "income offset," see George Tolley and C. Eugene Steuerle, "The Effects of Excises on the Taxation and Measurement of Income," 1978 Compendium of Tax Research. Washington, D.C.: Government Printing Office, 1978, pp. 67 - 78; and Sonia Conly and Linda Radey, "Changes in Excise and Payroll Taxes and Their Effect on Total Budget Receipts," paper presented at the 1988 Eastern Economic Association Meetings, Boston,

Federal income and employment tax liabilities are affected by these compositional changes, as the allocation between taxable cash wages and non-taxable compensation (including the employer portion of payroll taxes) shifts. Based on observable relationships within the NIA, wages and salaries would appear to fall by almost the full amount of an increase in employer contributions for health insurance. Wages and salaries do not fall by the full amount for several reasons. First, the reduction in wages automatically causes employer contributions for social insurance (another form of labor compensation) to decline. Further, to some extent, employer contributions for other fringe benefits, such as pensions and life insurance, will also fall.

Estimating the Effect of Required Employer Contributions for Health Insurance, Premium Discounts, and Cost Containment on Federal Receipts

Under the health reform plan, employers would be required to contribute towards the purchase of a comprehensive health insurance benefit plan for their workers. This package may cost either more or less than the health insurance plan currently provided by the firm, and its scope may also differ markedly from the firm's current plan. Employers' response to a requirement that they contribute toward their employees' health insurance will depend, in large part, on how the guaranteed comprehensive benefit package differs both in costs and generosity from their current plans and the extent to which they may be entitled to premium discounts under the proposal.⁹

Five key pieces of information are necessary to evaluate the impact of the health reform proposal on Federal receipts. These include:

- Initial cost of the comprehensive benefit package;
- Rate of growth in the cost of the comprehensive benefit package;
- Degree to which employers' costs are offset by premium discounts;
- Employees' demand for health insurance in excess of the comprehensive benefit package; and

Massachusetts.

⁹ The health reform plan affects revenues largely through its impact on the allocation between taxable wages and non-taxable health benefits. The plan can affect revenues in other ways as well. As insurance coverage expands as a consequence of the plan, some taxpayers will not incur large out-of-pocket expenditures for uncovered medical expenses, and deductible medical expenditures will also fall. Expansion of the Medicare benefit package to include prescription drugs may also reduce deductions for medical expenses.

- Employees' ability to negotiate with employers to obtain tax-preferred methods of paying for supplemental coverage and the employee share of the cost of the comprehensive benefit plans.

The data sources and the key underlying assumptions for each of these items are described briefly below.

Costs of the Benefit Package: The Health Care Financing Administration (HCFA) provided estimates of the costs of the benefit package at 1994 levels, assuming that the plan was fully effective in that year. Their estimates included the effects of moving to a system of universal coverage.

Rate of Growth in the Costs of the Benefit Package: All agencies involved in estimating the budgetary impact of the health reform plan used the same assumptions regarding the rate of growth in the cost of the benefit package. Under these assumptions, the basic benefit package was assumed to grow at a rate consistent with private health insurance between 1994 and 1996. Beginning in 1996, the costs of the plan were assumed to grow at the targeted rates of growth specified in the health reform plan (CPI+1.5 percentage points in 1996, CPI+1.0 percentage points in 1997, CPI+0.5 percentage points in 1998, and CPI in 1999 and 2000). These rates of growth are based on the assumption that the cost containment initiatives contained in the plan are effective.

Premium Discounts: Under the plan, premium discounts are provided to ease the burden for some employers. First, small firms with fewer than 75 employees and average wages below \$24,000 will be entitled to significant premium discounts. Second, the Federal government will provide premium discounts for other firms within the regional alliance if the cost of providing the comprehensive benefit package exceeds 7.9 percent of their payroll. Some employers will receive premium discounts even though they provided health insurance in the past. These employers are expected to pass the discounts back to workers in the form of higher wages and other benefits. Receipt of premium discounts, then, could affect the estimates of the plan on Federal receipts.

HCFA is responsible for producing the official estimates of the costs of the premium discounts. Using Treasury's Individual Tax Model, it is also possible to simulate the receipt of the premium discounts by individuals (as passed back to them by their employers). Treasury's estimates of the premium discounts were used solely as an input into the analysis of the effect of the plan on Federal receipts. As a check, OTA's estimates of the premium discounts are reconciled to those produced by HCFA.

Demand for Supplemental Coverage: Workers' demand for supplemental coverage is estimated largely as a function of expenditures on medical services for items not within the scope of the comprehensive benefit package. Data on reimbursable expenditures on health insurance, as well as current health insurance expenditures, are used to determine the value of supplemental health insurance coverage. Estimates of the costs of administering health insurance (the "load

factor") under the current system were provided by HCFA. The estimates also account for changes in the price and demand for supplemental coverage following health reform.

Cafeteria Plans and Other Tax-Preferred Arrangements with Employers: Under the Administration's health plan, individuals may be responsible for a portion of the cost of the comprehensive benefit package. They may be liable for the difference between the cost of the plan which they select and eighty percent of the weighted average cost of a plan within their region. As under current law, workers are generally required to pay for health insurance premiums out of after-tax income. However, the current system provides workers with several opportunities to reduce their health insurance costs by paying with pre-tax dollars. To the extent that workers can take advantage of these options, tax receipts will fall.¹⁰

The estimates of the required employer contribution (with premium discounts and cost containment) took into account the likelihood that individuals may seek ways to shelter, on net, more of their health insurance premiums through cafeteria plans and other informal arrangements with employers. The estimates also took into account other offsetting factors (such as some reductions in contributions which, under the current system, cover out-of-pocket reimbursements).

Estimating the Effect of Restricting Contributions for Health Insurance

Under the plan, employer contributions for the comprehensive (i.e., standard) benefit package (up to 100 percent of the costs of the package) would be excluded from income for purposes of calculating individual income and employment taxes. Employer-paid premiums on supplemental plans would now be included in employees' taxable income.

While this provision would generally become effective January 1, 2004, contributions for health benefits through cafeteria plans would be disallowed, effective January 1, 1997. As a consequence, the seven-year estimates of the revenue impact of health reform only show the impact of the restrictions on employer contributions through cafeteria plans.

OTA's estimates of the effects of the restrictions on cafeteria plans are "stacked" after the combined effects of the required employer contribution, cost containment, and subsidies have been taken into account. In other words, the baseline for cafeteria plans, in these estimates, assume that individuals have already made certain adjustments to other aspects of health reform. Thus, for example, the baseline would reflect changes in the utilization of the cafeteria plans in response to the required employer contribution.

¹⁰ As will be discussed further below, the Administration's plan would restrict contributions to cafeteria plans. The estimates of the effects of the required employer contribution do not reflect these proposed restrictions. The effects of these restrictions are estimated separately, under the assumption that employee behavior has changed in the ways described in this section.

When contributions to cafeteria plans are restricted, individuals may have alternative opportunities to shelter income through other tax-preferred arrangements with their employers (e.g., the employer may agree to pay the full amount of the employee contribution and, in turn, explicitly reduce wages by an offsetting amount). These alternatives for sheltering income are taken into account in the revenue estimates for restricting cafeteria plans.

**Methodological Description of
Health Care Reform Premium and Discount Estimates**

Contributions to this paper were made by:

- Department of Health and Human Services' Office of the Assistant Secretary for Planning and Evaluation
- The Office of Management and Budget
- Health Care Financing Administration's Office of the Actuary
- Agency for Health Care Policy and Research
- The Urban Institute's Center for Income and Benefits Policy

Contents

- I. Background
- II. Description of the Major Models
 - A. The Urban Institute's Transfer Income Model (TRIM2)
 - B. The Health Care Financing Administration's Special Policy Analysis Model (SPAM)
 - C. The Agency for Health Care Policy and Research's Simulation Model (AHSIM)
- III. Premium Estimation Under Reform
 - A. Health Care Financing Administration
 - B. Agency for Health Care Policy and Research
 - C. Choice of Premium Estimates for Budgeting Purposes
- IV. Discount Estimates
 - A. Employer Discounts
 - 1. TRIM2: Employer Discounts
 - 2. HCFA: Employer Discounts
 - 3. AHSIM: Employer Discounts
 - B. Discounts for the Self-Employed
 - C. Discounts to Low Income Families
 - D. Retiree Discounts
 - E. Choice of Discount Estimates for Budgeting Purposes and Distributional Analyses
- V. National Spending Impacts
- Appendix A: Example of the Application of an Induction Factor to a Change in Insurance Status

I. Background

Estimates of premium costs, national health spending, and government program costs under health care reform have been necessary in the decisions leading to a health care reform bill. During the basic policy development process, exploration of alternative policies required estimates of the cost impacts of each possible variation. Specific areas included analyses of premium caps, the impacts on businesses of required employer payments, the effects on households of required purchase of coverage, and the budgetary effects of the discount schedules.

The development of estimates of this type is obviously a complex task. Given that no single authoritative data set exists which captures all spending for all services through all sources of funding, numerous data sources were used in this process. Federal surveys, especially the National Medical Expenditure Survey (1987), offer the best characterizations of national spending. The National Health Accounts generated by the Health Care Financing Administration (HCFA) summarize the best available data on total national spending by type of service and source of fund. Producing estimated spending under health reform, however, requires developing a comprehensive baseline summary for literally hundreds of affected sub-populations, and then estimating the future spending patterns associated with the reform.

Estimates of future costs of reform are primarily derived through modeling transfers of current spending among the various channels of payment. Estimating the impacts of changing primary payers is relatively straightforward, given a baseline of national health spending. More difficult is estimating the net impacts of fee upgrades and paying for uncompensated care, since reimbursement levels will be set to achieve some amount of recapture of these increased outlays for current services. Also difficult is estimating the induced spending attributable to new or enriched insurance coverage. Estimates have been based upon experiences of government and private insurers as well as the results of academic studies of the demand for medical care.

Multiple data sources, methodologies, and models were needed to produce estimates of premiums, discounts, and the overall effects of reform options. Major contributors included the Health Care Financing Administration's (HCFA) Office of the Actuary (OAct), the Agency for Health Care Policy and Research (AHCPR), the Treasury Department, and other government agencies. Numerous consultants assisted in the process, with major modeling contributions provided by the Urban Institute. This paper provides an overview of the major models and their ways of estimating premiums, discounts, and overall health spending under health care reform.

II. Description of the Major Models

A. The Urban Institute's Transfer Income Model (TRIM2):

The Urban Institute has developed a microsimulation model called the Transfer Income Model (TRIM2). This model has been used to analyze the financing of national health care reform plans, and has particularly focused on the distributional effects of such proposals. TRIM2 is based upon the March 1992 Current Population Survey (CPS) and combines data from a number of other sources in order to provide a complete basis for assessing acute care health spending by the non-elderly in the U.S. population.¹ The complete model has been aged to 1994, and all results are presented in 1994 dollars. The following description of TRIM2 and its capabilities has been adapted from Zedlewski, Holahan, Blumberg, and Winterbottom (1993).

The TRIM2 model simulates the employer-based group health insurance system, nongroup or individually purchased health insurance, out-of-pocket spending, and the Medicaid program. The model assigns spending under these programs/systems at the individual and family levels and adjusts for regional variation in premium levels. It is then possible to

¹Historically, TRIM2 has been used to analyze current and alternative tax and transfer programs. See National Research Council (1991) and Lewis and Michel (1990) for a more complete description of the properties of this model and its recent applications.

assess the distributional effects of the financing of the current health care system. Detailed tax calculations allow the analysts to examine health spending on an after-tax basis and to calculate the after-tax value of employment-based health benefits. TRIM2 can also be used to simulate the distribution of health spending and health care financing burdens under alternative assumptions about how insurance would be provided and financed. Each component of the basic model is presented below.²

1. Employment-Based Group Health Insurance. TRIM2 examines reported insurance coverage for individuals and families on the CPS to determine the number of family members who share coverage under an employment-based policy.³ The model assigns an employment-based health insurance premium, including the shares paid by the employer and the employee, to each covered worker based on two 1989 private, employer-based surveys (from the Health Insurance Association of America and Foster-Higgins) and federal health insurance plan documents. These private surveys represent firms of different sizes, in all major industries (including state and local government), and in all regions of the country. Federal health insurance plan documents include information about premiums for single and family coverage and how these premiums are distributed between the employer and worker. TRIM2 statistically matches workers to health plans based on variables that the employer insurance plans and workers on the CPS have in common. These include the type of coverage (single or family), location, industry, the size of firm, and whether or not the worker has to pay part of the insurance premium.

2. Private, Nongroup Health Insurance. TRIM2 estimates premiums for the families and individuals on the CPS who report insurance coverage through private, nongroup, health insurance policies. It does this by matching these people with plan data collected from Blue Cross and Blue Shield Plan offices across the U.S. Plan documents included premiums for typical health insurance plans covering single individuals, families, and dual (adult and child)

²Giannarelli (1992) describes the full TRIM2 model.

³Zedlewski (1991) describes this model in more detail.

insurance units in each state. The method does not, however, capture differences due to families' insurance preferences or income levels. For example, if low (or high) income families reporting private, nongroup health insurance are more likely to purchase catastrophic policies, the model will overstate their premiums. Conversely, the model will understate premiums for families who prefer broader coverage than that included in the prototypical plan.

3. Medicaid. TRIM2 uses detailed sets of algorithms to replicate the rules of state Medicaid programs.⁴ These algorithms identify Medicaid eligibles as all persons who meet the states' categorical, asset, and income criteria in effect July 1991. The model has procedures for selecting Medicaid enrollees from those who are eligible. The second part of the model imputes the insurance value of Medicaid. Separate estimates are made for adults, children, and the disabled; estimates also vary by age, sex, race, urban or rural residence, reason for enrollment, and number of months in the program. The model uses Medicaid state expenditure data to adjust for differences among states in program generosity and the cost of health services.

4. Out-of-Pocket Spending. The model uses data from the Consumer Expenditures Survey to predict out-of-pocket spending (other than health insurance premiums) for families on the CPS.⁵ Separate equations were estimated for persons with private insurance coverage, Medicaid, and for those uninsured. The equations predict the incidence and levels of spending as a function of families' socioeconomic characteristics including region of residence, income, the age-sex distribution of family members, and the family head's marital status, education, race, and work status.

5. Income and Payroll Taxes. The model calculates family disposable income and estimates the amount of income and payroll taxes required to finance health care spending by

⁴See Holahan and Zedlewski (1989) for a full description of this model.

⁵See Wade (1991) for a full description of this model.

the federal government through the Medicaid and Medicare programs. Other federal taxes (such as corporate, estate, and excise taxes) are not included.⁶ The portion of Medicaid and Medicare spending that is financed through the federal personal income and payroll tax systems is calculated and can be allocated to families. The model can also calculate income and payroll taxes under the assumption that employer-paid health insurance premiums are taxable to estimate the tax value of this employee benefit.

6. Total Health Care Spending for the Nonelderly. The TRIM2 baseline distribution of direct spending from various sources accounts for most health spending for the nonelderly. The TRIM2 model excludes the institutionalized population. In addition, Medicare benefits for the nonelderly and military health benefits are excluded. Nevertheless, the model accounts for nearly all of the spending under systems that would be most affected by health care reform alternatives currently under debate.

7. Adjustments to TRIM2 Baseline Output. Two significant adjustments were made to the TRIM2 baseline health spending simulations at the request of the office of the Assistant Secretary for Planning and Evaluation (ASPE), Department of Health and Human Services (DHHS). Both employer health insurance premiums and private nongroup health insurance premiums in TRIM2 were downwardly adjusted to reflect health care reform premiums estimated by the Office of the Actuary (OACT). The TRIM2 employer plan data include employer spending for dental care and a few other benefits that not fully covered by the reform package. Without this adjustment for differences in coverage, employer and family spending under reform as calculated in TRIM2 (using HCFA OACT premiums) would not be comparable to employer and family spending under the current system according to TRIM2. Thus, estimated changes in spending under reform compared to current spending would be distorted without reconciling the spending levels.

⁶However, the TRIM2 model does have the capacity to simulate excise tax payments on alcohol and cigarettes.

B. The Health Care Financing Administration's Special Policy Analysis Model (SPAM):

The Health Care Financing Administration's (HCFA) Special Policy Analysis Model (SPAM) database is also based upon the March 1992 Current Population Survey (CPS). The March 1992 CPS acts as the host file, with each person on it being statistically matched to a person on the 1987 National Medical Expenditure Survey (NMES). Health expenditures and utilization from the NMES person record are then linked to the CPS record, and the entire data set is controlled to be consistent with 1994 National Health Account data.

The parameters used in the linking the NMES file to the CPS were disability status (disabled or not), age and gender (male adult < 19, male adult 19-44, male adult 45-64, male adult 65+, female adult < 19, female adult 19-44, female adult 45-64, female adult 65+, dependent child < 19, and dependent child 19+), family income (family under 100% of poverty, family 100% to 185% of poverty, family at or above 185% of poverty), and insurance class of the person (employer sponsored insurance and Medicare, employer sponsored insurance and Medicaid, other employer sponsored insurance, Medicare and Medicaid and other private insurance, Medicare and Medicaid, Medicare only, Medicaid and other private insurance, Medicaid only, other insurance, and uninsured).

For a CPS person to be considered disabled, one of the following situations had to be true: (a) person was a veteran, collecting veteran's disability, (b) person collected over \$10,000 in workers compensation, (c) person had disability income, or (d) person was under 65 and had SSI income. For a NMES person to be considered disabled, one of the following had to be true: (a) person was a disabled veteran, (b) person didn't work due to disability/illness, or (c) person was without a job due to disability/illness.

The determination of adult vs. child was made from "insurance families," which were appended to both the CPS and NMES files. These families were created using standard insurance industry definitions. Within an insurance family there can be one or two adults (single or married couple), and any number of dependent children (or none).

The insurance classifications were hierarchical, and made on the person level using the appropriate variables on both the CPS and NMES. NMES insurance classifications were converted from round data⁷ to "ever insured" data (for example, if a person had Medicare in one of the rounds of the NMES survey, they were coded as having Medicare). Poverty classifications were calculated by adding income of all insurance family members together and comparing it to the appropriate poverty standard for the year in question (1991 for the CPS and 1987 for NMES), for the appropriate family size.

Once each CPS person was linked to a NMES record, expenditure data by service (hospital inpatient, hospital outpatient, etc.) and source of payment (out-of-pocket, private insurance, Medicare, Medicaid, etc.) were attached. This file was then aged to 1994 through two steps. First, the 1992 CPS population was weighted to sum to the 1994 Social Security Administration (SSA) non-institutionalized population (about 20 million more than Census estimates). This was done by age (20 age groups), gender and marital status (single, married, divorced, and widowed).

Second, the total national health expenditures by this SSA-weighted CPS population (the SPAM population) were then "benchmarked" by service category, channel of payment, and age category to the aggregate totals in the projected 1994 National Health Accounts. There are 13 service categories: hospital inpatient, hospital outpatient, hospital emergency room, physician inpatient, physician outpatient, physician emergency room, physician office visit, other professionals, prescription drugs, home health care, dental, vision, and other durable medical equipment. There are eight channels of payment: private health insurance, out of pocket, Medicare, Medicaid, other federal, other state and local, workers compensation, and other private. There are three age categories: under 19, 19 to 64, 65 years and over.

An example of how this benchmarking worked is as follows. Suppose the ratio of current

⁷NMES-2, described more fully in the following section, involves 4 surveys of each family over a period of 16 months. Each of the 4 interview sessions is referred to here as a "round."

SPAM out-of-pocket inpatient hospital spending for persons under age 19 to NHA-consistent spending for the same cell is 0.9. Then each SPAM person's inpatient hospital spending total is multiplied by 1.11. The only divergence from this logic was that out-of-pocket spending for the uninsured was controlled separately from out-of-pocket spending for the insured population (which was thought to have risen at a rate closer to the rate of inflation in insurance).

C. The Agency for Health Care Policy and Research's Simulation Model (AHSIM):

AHSIM is based on AHCPR's 1987 National Medical Expenditure Survey (NMES-2), which is the most recent national effort to collect comprehensive, person-level profiles of health care use, spending, and insurance coverage. AHSIM currently is designed only to analyze the nonelderly (under 65), noninstitutionalized civilian population residing in the United States. Although the NMES-2 data were collected in 1987, demographic variables have been aged forward by reweighting individual records. New weights take into account changes in the distribution of the population by age, race, sex, insurance status, and poverty status observed between the November 1987 and March 1992 Current Population Surveys. Additional demographic aging is based on Census projections of the population by age, race, and sex beyond 1992. Real growth in service-specific health expenditures and insurance premiums have been incorporated through adjustments based on the appropriate rates of changes in HCFA's National Health Accounts and its projections.

AHSIM draws primarily on the NMES-2 Household Survey and its two derivative components, the Health Insurance Plan Survey (HIPS) and the Medical Provider Survey. The Household Survey sample is representative of the civilian noninstitutionalized population of the United States in 1987. Each family in the Household Survey was interviewed four times ("rounds") over a period of 16 months to obtain information about the family's health and health care during calendar year 1987. Roughly 35,000 individuals and 14,000 households completed all rounds of data collection. The Medical Provider Survey obtained information directly from the physicians, hospitals, and other providers used by a portion of the household

sample. These data were used to edit and supplement household survey data describing use of and spending on health services. HIPS data were collected from employers, unions, and insurers and include premiums paid by all sources and specific provisions of baseline private insurance coverage. They also provide information about the organizations offering insurance coverage and include in the case of employers, firm and establishment size, industry, and location.

Other data sources were incorporated when needed for specific purposes. For example, survey data from the Health Insurance Association of America were used to project market shares for fee-for-service, HMO, and preferred provider health plans by region. Annual survey data from the American Hospital Association were used to determine the allocation of hospital spending between inpatient and outpatient services and to identify local areas in which at least one HMO is operating. County Business Patterns data were used to impute average payroll for employers, using a statistical match based on industry, location, and firm size. The Internal Revenue Service (IRS) Statistics of Income (SOI) data were used to expand NMES-2 income data and to calibrate the AHSIM tax module. Further details of the basic AHSIM Model are presented below.

1. Employment-Based Group Health Insurance. AHSIM does not model employers, only households and individuals. HIPS and Household Survey data measured the scope of employment-based insurance in 1987, as well as the allocation of premiums among employers, employees, and other sources (primarily unions). AHSIM assumes that any changes in the pattern of availability, benefits, premiums, or other plan provisions between 1987 and 1994 are controlled for in the aging process, using CPS and HCFA aggregate data.

2. Private, Nongroup Health Insurance. AHSIM handles people with private, nongroup insurance in the same way as it does those with employment-based insurance. This means, for example, that a tendency for people with systematically higher medical expenditures to purchase private, nongroup health insurance will be captured in the model.

3. Medicaid. NMES-2 measured Medicaid program participation directly. Since 1987, however, Medicaid eligibility has been expanded to include low-income pregnant women and children who are not otherwise categorically eligible. This Medicaid expansion was incorporated into the AHSIM model by identifying household survey respondents who would have become eligible for Medicaid benefits by 1994 and modifying their baseline insurance status accordingly. Baseline health spending for new Medicaid recipients was also modified to reflect the effect of a changes insurance status, using the same methods that were used to project estimates for the uninsured after reform.

4. Out-of-Pocket Spending. NMES-2 directly measures baseline out-of-pocket (OOP) spending on cost-sharing and noncovered services for all household survey respondents. However, because the AHSIM model cannot use actual NMES-2 expenditure data directly, data on OOP spending reported in the household survey are used to develop a set of estimates that can be incorporated into the model.⁸ In particular, a system of equations was estimated to predict the percent of expenses paid out-of-pocket in the baseline as a function of demographic characteristics, insurance coverage, health status, and other relevant explanatory variables. These equations were then used to impute baseline OOP spending as a percent of imputed total spending, by type of service. While baseline expenditures are imputed in the AHSIM Model, they are still internally consistent with the rest of the NMES-2 data because the estimation procedures preserve the pattern of spending observed in the original household survey data.

5. Income and Payroll Taxes. The AHSIM model distinguishes between households and tax filing units. The effect of wage changes induced by employer mandates on federal

⁸Actual NMES-2 expenditure are not used as baseline spending in the AHSIM Model for two reasons. For some people, e.g., those affected by the expansion of Medicaid eligibility, baseline insurance status is different than what it was in 1987 when the NMES data were collected. In addition, it is important that reform expenditures only differ from baseline for reasons related to reform. Because reform expenditures must be predicted for people based on their "new" insurance status, it is helpful to predict baseline spending with the same methodology.

personal income and payroll taxes can be calculated with respect to the 1991 tax treatment of employer paid premiums.

6. Total Health Care Spending for the Nonelderly. The AHSIM baseline includes most health spending by the civilian, resident population of the United States under the age of 65. AHSIM excludes the institutionalized population, Medicare beneficiaries among the nonelderly, and spending by active-duty military personnel.

7. Adjustments to AHSIM Baseline Data. Because the aggregate health insurance premiums reported in the HIPS component of NMES-2 are not consistent with the benefits paid by private health insurance according to either the Household Survey or the National Health Accounts, the NMES-2 HIPS-based premiums are calibrated to these other data sources. Tax estimates and wage income are calibrated to SOI data, as described above. In general, according to extensive analysis by HCFA and AHCPR staff to account for differences in definition and coverage, the NMES-2 expenditure data and the National Health Accounts yield similar estimates.

III. Premium Estimation Under Reform

Two agencies, the Health Care Financing Administration and the Agency for Health Care Policy and Research, estimated the cost of health insurance premiums under reform. Their estimates are in 1994 dollars and reflect the benefits included in the standard benefit package. The premium estimation methodology used by each of these agencies is described below.

A. Health Care Financing Administration:

The first step in HCFA's simulation process was to determine each individual's insurance status. The modelers used CPS indicators for this, and considered a person to be insured if he/she was covered by employer-sponsored insurance, other private insurance, CHAMPUS, Medicare, or Medicaid. Insurance could be either in one's own name or through inclusion in a policy held by an adult in the insurance unit. Also, some dependents are covered by private insurance policies owned by people outside the family (for example, a child of divorced

parents may be covered through insurance carried by the parent who does not live with the child).

HCFA modelers then adjusted health expenditures to reflect the coverage offered through the regional alliance plan. That coverage is restricted to hospital care, physician and other professional services, prescription drugs, and durable medical equipment other than vision and hearing products. Therefore, the analysts excluded all other National Health Accounts expenditure categories. The cost of coverage for mental health, dental, and preventive care in the standard benefit package was estimated separately, from aggregate data, and added in at the end of the process. Once expenses were adjusted for coverage differences, the modelers applied the fee-for-service plan deductibles, coinsurance, and cost-sharing limits to each person covered through the regional alliance.

An insurance-induced demand adjustment was applied to all those enrolled in the regional alliance. The basis for the induced demand was the difference between out-of-pocket spending under current law and that determined by the reform simulation described above. The induction factor varied by type of service. The application of the factors and the specific values used are described in appendix A. Post-induction spending is equal to the expenditures calculated previously plus (minus) the induced spending calculated as described.

Following these steps, HCFA analysts imputed expenses to currently uninsured people. Existing patterns of use for the uninsured person were discarded, because those patterns are influenced by the absence of insurance. An imputation file was created for each service covered under the regional alliance. To create the file, insured people (excluding people who received SSI cash payments) were divided into groups according to gender, four age classes, and three poverty status classes. Expenditures were tabulated for each group to determine: (a) the proportion that had no expenditure and (b) mean expenditures and use for each decile of the user distribution.

Expenses were imputed for an uninsured person using these imputation files. For each

type of service, the person was assigned a random number ranging from 0 to 1. If that random number fell within the nonuser proportion for the service, the person was given no expenditure for the service. Otherwise, the person was given the mean expenditure and use for the decile of users into which the random number placed them. Analysts assumed that facility and physician use was correlated for hospital services, and used the same random number for hospital inpatient and physician inpatient use. They did the same for hospital outpatient and physician outpatient, and for hospital emergency room and physician emergency room use.

Analysts performed a final simulation to determine which people were covered by the alliances. Typically, they excluded people who received AFDC or SSI cash payments. Similarly, most Medicare enrollees were excluded; only those who worked or whose spouse worked were included in the premium calculations. The remaining people were divided between the corporate alliance and the regional alliance according to the worker status of the adults in the insurance family, and were assigned to one of three policies: individuals (and couples with no dependents), one adult plus dependents, and two adults plus dependents. In a final pass through the family's health expenditures, analysts applied the family limits on out-of-pocket spending to determine the plan benefits and copayments.

In order to generate an upper-bound discount estimate, whenever a two-earner couple had one worker in a large firm (5,000 or more workers) and one in a firm that would be covered through a regional alliance, the couple was assumed to choose coverage in the regional alliance. This maximizes the potential cost of the discounts costs given that no government discounts are available through the corporate alliances.

After plan benefits had been determined, premiums were calculated for each of the policy types and alliance types. An offset was applied to expenses to reflect current-law cost-shifting attributable to uncompensated care. Under the current system, private sector premiums are higher than they would be if there were no uncompensated care in the system since providers pass these unpaid costs on to insured, paying patients. Under reform, all

persons will be insured; consequently, baseline premiums should be reduced to reflect the elimination of non-payers from the system. A load factor was applied to the (reduced) benefit cost per policy. The load factor was 15 percent for the regional alliance.

B. Agency for Health Care Policy and Research:

AHCPR's method of generating premium estimates has seven steps. First, following conventions in health economics, AHSIM estimates a two-part model of expenditures for each service. The unit of observation is the person. The first equation in each service's set of two equations estimates the probability of using the service at all as a function of demographic, income, insurance, employment, and health status measures from the 1987 NMES-2. The second equation estimates annual expenditures on the service for all users of the service, as a function of the same explanatory variables. Combining the result of these equations (i.e., multiplying the probability of use times the coefficients in the second equation) yields an equation that predicts expenditures for each type of person. Predicted expenditures are aged to 1994.

Health expenditures for each person are then predicted for each of the ten services included in the AHSIM Model using this system of equations. Predictions for both the probability and the level (given any use) of an expense were made for each person based on these regressions. The procedure assigns the same expected values to people with private insurance and similar personal characteristics, based on a hypothetical "average" insurance policy. Expected values are modified to take into account specific plan provisions using information from the RAND National Health Insurance Experiment about the effects of such provisions. Reform expenditures are imputed to all people in the model using a stochastic process that maintains observed correlations in expenditures across service types while controlling for the demographic characteristics and health status of individual NMES-2 respondents.

Every individual included in the AHSIM Model actually had three types of reform expenditures assigned to them, indicating their (assumed) behavior under fee-for-service

(FFS), managed care (HMO), and preferred provider (PPO) insurance arrangements. Expenses for benefits paid, cost-sharing and noncovered services were calculated separately for each type of plan by applying claims-processing logic to the appropriate estimated expenditure. Premiums for each type of insurance plan were computed on the basis of average benefits paid per insurance policy plus an administrative load set at a percent of benefits paid. In this way, each person was taken into account in computing initial premium levels. Premiums were adjusted for current regional variations in prices.

Individual choice of health plans under reform was modelled by randomly assigning health insurance units to one of the three types of plans (FFS, HMO, PPO) described above. The assumed probabilities of selecting particular plans were based primarily upon market shares observed by HIAA in their annual surveys, trended forward to 1994. These estimates were modified by assuming a 10 percent reduction in FFS under reform as a result of managed competition. Market shares were allowed to vary on the basis of region, urban/rural location, and the availability of discounts for out-of-pocket (OOP) expenses and premiums.

Two passes through the data are made to compute the final set of premiums. The first pass implements decision rules regarding the distribution of premium payments under reform. It also computes the cost of noncovered services and cost-sharing requirements borne by individual households. Based on these calculations, the model determines the extent to which a household's direct costs will be offset by supplemental insurance and OOP discounts. In the second pass through the data, expenditures are increased to reflect additional spending induced by supplemental insurance and OOP discounts. Insurance premiums are then adjusted to reflect these higher expenditures.

C. Choice of Premium Estimates for Budgeting Purposes:

One set of premium estimates had to be chosen for final budgeting purposes. Although AHCPR's premiums were used by that agency in their estimation of discounts to employers and households and those discount estimates were used as a check on estimates done by HCFA and the Urban Institute, the Administration opted to use the HCFA premiums for

purposes of final federal budgeting and distributional effects analyses.

This choice was made for two reasons. First, the premiums estimated by HCFA were higher than those estimated by AHCPR, and it was viewed as desirable to have an official estimate that was more conservative (i.e., that would lead to higher costs associated with the program -- see Table 1 below). Second, the HCFA estimates are benchmarked to the National Health Accounts, the most reliable measure of aggregate spending in the current health care system. Given that the National Health Accounts are considered to be the "gold standard" in measuring total health expenditures, it seemed most appropriate to keep the official premium estimates consistent with that standard.

Table 1
Alliance Premium Estimates

Policy Type:	HCFA	AHCPR
Single	\$1933	\$1735
Couple	\$3865	\$3471
One Adult Family	\$3894	\$3647
Two Adult Family	\$4361	\$4262

IV. Discount Estimates

The national health care reform plan includes a number of different discounts, targeted at different payers. There are two employer discounts: one directed at all firms in the regional alliance, and one directed at small firms with less than 75 employees. There is a discount for the family share (20 percent of the actuarial value) of premiums and for out-of-pocket

payments for both working and nonworking low income families. There is also a discount for the 80 percent premium share for those families who do not have at least one full time worker (or equivalent), including early retirees. The major models are similar in how they estimate most components.

A. Employer Discounts:

The general firm discount consists of a 7.9 percent of payroll cap on all firm premiums, regardless of firm size, provided the employer is in the regional alliance. If the cost of providing 80 percent of the adjusted premium per worker exceeds 7.9 percent of firm payroll, the share paid by the federal government is equal to the difference between the two amounts, or:

$$[N_S(.8P_S) + N_C(.8P_C) + N_{SP}(.8P_{SP}) + N_{DP}(.8P_{DP})] - (.079 * \text{firm payroll})$$

where N is the number of workers of each contract type (S=singles, C=couples without children, SP=single parent families, and DP=dual parent families) and P is the adjusted per worker premium for each contract type.

The small firm discount schedule provides lower payroll caps (less than 7.9 percent) for firms with less than 75 employees and average pay below \$24,000 per year. The small firm schedule is shown in Table 2.

Table 2
Small Firm Discounts

Average Firm Payroll	Size of Firm ⁹ (Number of Employees)		
	Less Than 25	25 to 50	50 to 75
Less \$12,000	3.5%	4.4%	5.3%
\$12,000-15,000	4.4%	5.3%	6.2%
\$15,000-18,000	5.3%	6.2%	7.1%
\$18,000-21,000	6.2%	7.1%	7.9%
\$21,000-24,000	7.1%	7.9%	7.9%
Greater Than \$24,000	7.9%	7.9%	7.9%

⁹Because 75 workers was not a firm size break included in the data sets being used, modelers were asked to use a firm size of 100 for this subsidy calculation. Given that the subsidies will apply only to firms up to size 75, the results overestimate the subsidy costs.

1. TRIM2: Employer Discounts. In the TRIM2 model, employer obligations (either 80 percent of the adjusted premium for each worker or a percent of total payroll) are calculated for each worker; there are no firms per se on the CPS, although each worker has employer information associated with them. TRIM2 assigns firm average payroll information from the County Business Patterns (CBP) data to each worker, using a statistical matching procedure that relies on industry (the 3-digit SIC codes), state of residence, and establishment size.

In addition, an average firm premium is imputed to each worker. Take, for example, retail firms with 100-500 workers. Assume that according to the CPS, of the workers who report being employed by that type of firm, 40 percent are singles, 20 percent are married but have no children, 30 percent are married with children, and 10 percent are single parents. The weighted average firm premium that an employer of that type faces is equal to

$$(.4P_S) + (.2P_C) + (.1P_{SP}) + (.3P_{DP})$$

where P_S , P_C , P_{SP} , and P_{DP} are as described earlier.

The employer's payment is proxied by the comparison of average pay times the appropriate percentage cap (3.5 percent to 7.9 percent) to 80 percent of the average firm premium. If the 80 percent of the average firm premium is less than capped average pay, the employer would pay 80 percent of the correct adjusted premium for each worker. If, on the other hand, capped average pay is less than 80 percent of the average firm premium, the employer would contribute 7.9 percent (or the appropriate percentage less than 7.9 percent) of total payroll to the alliance.

If the firm cap is the less expensive option, the worker's record is appended with an employer payment equal to the appropriate cap times average pay in the firm. The amount paid by the federal government on behalf of the employer is also added to the record in the amount of:

$$(.80P_i) - (CAP * (Avg. Firm Pay))$$

where P is the adjusted per worker premium for the worker's health insurance unit type i (single, couple, single parent, dual parent), CAP is equal to the appropriate percentage cap (ranging from 3.5 percent to 7.9 percent) and Avg. Firm Pay is equal to the firm's average payroll as imputed from the CBP data.

If, conversely, 80 percent of the adjusted per worker premium is the less expensive option, the worker's record is appended with an employer payment equal to $.80 * P_i$, where i is equal to the appropriate health insurance unit type for that worker, and there is no government employer discount.

2. HCFA: Employer Discounts. In the SPAM model, the basic calculations of employer discounts are similar to those in TRIM2, other than the development of firm-level average payrolls. While TRIM2 imputes payroll data from the County Business Patterns data set, SPAM uses payrolls created by synthesizing firms from employees on the CPS. For each record of an employee on the CPS, one of the firms created using that employee is linked back to serve as the firm description for that employee. The resulting payroll distribution is similar to that implied by the CBP.

3. AHSIM: Employer Discounts. In the AHSIM model, the calculations are also similar to those in TRIM2. AHCPR uses County Business Pattern data for estimating average payroll. The links to NMES-2 make use of the Household Survey detailed responses by firm-size, industry, and other variables, confirmed by the NMES-2 Health Insurance Plan Survey.

B. Discounts for the Self-Employed.

Those individuals who are self-employed are obligated to make a contribution to the alliances based upon the same schedule used to determine small business payments. Those with self-employment income between \$0 and \$12,000 per year, for example, pay the lesser of 3.5 percent of self-employment income and:

$$(.80 * P_i) - EC$$

where P_i is as before and EC is the credit received by the self-employed person due to employer contributions made on their behalf while doing wage work. So, for example, a self-employed person who is also employed by a firm and who is working a full-time, full-year job for wages/salaries has no further obligation with regard to the 80 percent/employer share. An individual who works full time for wages for 8 months and then quits that job and becomes self-employed is only obligated up to a maximum of 4 months of the 80 percent of the adjusted per worker premium for his/her health insurance unit type.

C. Discounts to Low Income Families.

Low income workers and non-workers (those with family income less than 150 percent of poverty¹⁰) are eligible for government discounts to assist in the payment of the family share of the premium and to assist with family out-of-pocket payments (co-insurance and deductibles). The family premium share discounts work as follows:

1. Those with family incomes at or above 150 percent of poverty are responsible for paying the full 20 percent share, subject to a maximum of 3.9 percent of family income.
2. Those with family incomes below 150 percent of poverty have their premium obligation calculated as:

$$MARG_1(INC_1 - 1000) + MARG_2(INC_2 - INC_1)$$

where INC_1 is equal to the family income up to the appropriate poverty guideline, INC_2 is equal to family income if it exceeds 100 percent but is less than 150 percent of the appropriate poverty guideline, $MARG_1$ is the contribution rate applied to family income below

¹⁰The family size specific poverty guidelines used are as follows:
 single -- family size is 1
 couple -- family size is 2
 single parent family -- family size is 3
 dual parent family -- family size is 4.

poverty, and $MARG_2$ is the contribution rate applied to family income between 100 and 150 percent of poverty.

The two contribution rates are such that families below poverty do not pay more than 3 percent of income for their family premium share contribution, those with income below \$1000¹¹ have no premium contribution. Families at 150 percent of poverty pay the full 20 percent share, or 3.9 percent of family income, whichever is less. The government payment is equal to 20 percent of the actuarial premium for the health insurance unit type, less the family contribution calculated above. For purposes of this calculation, family income is equal to adjusted gross income less unemployment compensation plus non-taxable interest income.

For each marginal rate ($MARG_1$ and $MARG_2$), there are two sets of rates to be used. The first set ($MARG_{1single}$, $MARG_{2single}$) is applicable for single health insurance units and uses the poverty guidelines for a family of size one. The second set ($MARG_{1other}$, $MARG_{2other}$) is applicable to all other health insurance units and is based on the poverty guidelines for a family of size four.

Set one is calculated as follows:

$$MARG_{1single} = (0.03 * POVG_1) / (POVG_1 - 1000)$$

$$MARG_{2single} = ((0.2 * PREM_s) - (0.03 * POVG_1)) / (0.5 * POVG_1)$$

where $POVG_1$ is based on the poverty guidelines for a family of size one, and $PREM_s$ is the premium for a single individual. In 1994, these rates are estimated to be 3.5 percent and 4.8 percent, respectively.

Set two is calculated as follows:

¹¹In 1994 dollars. The income "disregard" is indexed by the CPI in future years.

$$MARG_{1_{other}} = (0.03 * POVG_4) / (POVG_4 - 1000)$$

$$MARG_{2_{other}} = ((0.2 * PREM_{DP}) - (0.03 * POVG_4)) / (0.5 * POVG_4)$$

where $POVG_4$ is the poverty guideline for a family of size four, and $PREM_{F2}$ is the premium for a dual parent family. In 1994, these rates are estimated to be 3.2 percent and 5.8 percent, respectively.

These rates result in singles and dual parent families paying their full 20 percent premium share at 150 percent of poverty. At 150 percent of poverty, singles pay 3.6% of their income and dual parents families pay 3.9 percent. When the second set of marginal rates are applied to single parents and couples, these families are paying approximately 3.9 percent of their income at 150 percent of their appropriate poverty guideline (family size set at three for single parents and two for couples); however, that amount is less than 20 percent of their respective premiums. Consequently, couples and single parents with incomes in excess of 150 percent of poverty will be required to pay the lesser of 20 percent of their premium and 3.9 percent of income.

An out-of-pocket spending discount is available for those families below 150 percent of poverty who live in an area that does not provide access to a low cost sharing (HMO) plan. In such cases, the family is only obligated to pay the cost sharing that would be required if the family had actually enrolled in an HMO (i.e., \$10 copayment for outpatient services); and discounts will be available for the remainder.

Families without at least one full time worker or equivalent¹² may be required to pay at least some portion of the 80 percent adjusted premium share that is covered for workers

¹²Two examples of families with a "full time worker equivalent" are:

1. each spouse works half time for the full year;
2. one spouse works full time for 8 months and the other works full time for 4 months.

through their employers. Families with non-wage income below 250 percent of poverty are eligible for some subsidization of this obligation. If eligible, a family's payment for this portion of the premium is equal to:

$$MARG_3(NWINC_1 - 1000) + MARG_4(NWINC_2 - NWINC_1)$$

where $NWINC_1$ is equal to the family non-wage income up to the appropriate poverty guideline, $NWINC_2$ is equal to family non-wage income if it exceeds 100 percent but is below 250 percent of the appropriate poverty guideline, $MARG_3$ is the contribution rate applied to family non-wage income below poverty, and $MARG_4$ is the contribution rate applied to family non-wage income between 100 and 250 percent of poverty. $MARG_3$ is set such that families below poverty do not pay more than 5.5 percent of their non-wage income for this portion of the premium, and families with less than \$1000 in non-wage income have no required contribution towards this portion of the premium. The federal payment is equal to 80 percent of the appropriate adjusted per worker premium less employer payment credits, less self-employment contributions, and less family contributions as defined above.

Non-wage income is calculated as Adjusted Gross Income (AGI) less wages and salaries less unemployment compensation and less self-employed income.¹³ Income in this category includes: rents and royalties, interest (including non-taxable interest income), dividends, alimony, capital gains/losses, the taxable portion of social security, partnerships, and trusts. Aside from items mentioned above, other categories of excluded income are: welfare payments, VA benefits, worker's compensation, child support income, inherited money, and proceeds from life insurance.

There are four sets of contribution rates which can be applied to non-wage income: one each for single, couples, single parent, and dual parent families. They are calculated using the formulas shown below, using the family sizes of 1, 2, 3, and 4 respectively to determine

¹³The actual legislation excludes wages and salaries up to \$60,000 per year. Wages and salaries in excess of this amount count towards this calculation. The \$60,000 exclusion cap was not modelled, making the subsidy estimates somewhat over-stated.

poverty guidelines.

For family type 'i':

$$MARG_{3_i} = (0.055 * POVG_i) / (POVG_i - 1000)$$

$$MARG_{4_i} = ((0.8 * P_i) - (0.055 * POVG_i)) / (1.5 * POVG_i)$$

where $POVG_i$ is the poverty guideline for the appropriate family size, and P_i is the appropriate adjusted per worker premium. In 1994, these rates are estimated to be as follows: for singles, 6.4 percent and 10.7 percent; for couples, 6.1 percent and 10.9 percent; for single parent units, 6.0 percent and 9.8 percent; for dual parent units, 5.9 percent and 7.5 percent.

These rates were calculated so that families pay their full employer share of the premium at 250 percent of poverty.

D. Retiree Discounts.

Families with retirees¹⁴ are eligible for a special discount. When fully phased in, government discounts cover the full 80 percent/employer share for non-working retirees. Government discounts are offset to some extent by the employers of retirees who work part time and the employers of working spouses. For example, a 58 year old man who is working half time will have half of his employer contributions made by his employer and half of his contributions will be made by the federal government. No government discount is necessary when a retiree has a full time working spouse, as the spouse's employer's contributions will fulfill the coverage responsibility. However, if a retiree is married to a non-worker, the government contribution will cover the couple (or family).

¹⁴The policy defines retirees as those nonworkers who have fulfilled a requirement of a minimum number of working quarters and who are between the ages of 55 and 64, inclusive. However, the models being used to simulate the cost of the plan do not have data on quarters worked. Consequently, all individuals 55 to 64, who are not working or work part time or part year, are modelled as being eligible for the special retiree subsidy.

E. Choice of Discount Estimates for Budgeting Purposes and Distributional Analyses:

For reasons noted above in the section on premium estimation, the HCFA premiums were selected as the official Administration estimates. This choice necessitated that a model using the HCFA premiums be used as the official Administration discount estimates. For this reason, the discount estimates used for budgeting purposes are from the HCFA simulation model. It should be noted however, that all three discount estimates were within 7 percent of each other. Consequently, all estimates are well within the discount "cushion."¹⁵

For purposes of distributional analyses, the Administration's official estimates come from the Urban Institute's TRIM2 model, which was benchmarked to the National Health Accounts and which used the HCFA estimated premiums. The Urban Institute is the most experienced of the three groups in doing the type of complex distributional analyses needed for the reform process.

V. National Spending Impacts

The change in spending produced by health reform can be summarized in terms of the impacts on businesses, households, and governments. Present business spending is here limited to employer contributions for employer-sponsored health insurance and for active workers and retirees. Under reform, employers are required to pay 80 percent of the average worker premium in their area (net of discounts) for most workers. Beyond the required outlays, it is expected that there will be supplementation of the required coverage. Those employers currently paying more than the required employer contribution percentage, or buying richer coverage (e.g., lower cost-sharing) are assumed to continue to pay more than the required minimum.

The calculations of changes in business outlays are similar in TRIM2 and SPAM. If an

¹⁵The HCFA discount estimates were increased by 15 percent in an effort to budget a more conservative level of discounts.

employer currently pays more than 80 percent of premiums, TRIM2 increases employer spending under reform to match the proportion contributed by the employer currently, as long as this does not exceed current spending. If maintenance of the current proportion would exceed current spending, it is assumed that employers increase their spending only to the point of current spending. Worker contributions are reduced accordingly. This first part of supplementation is then increased to add the cost for enhancing the richness of coverage up to the current level of plan richness associated with each currently insured worker. The cost of matching the current richness of benefits is paid by the employer and the worker in proportion to current premium contributions.

In the SPAM model, additional coverage is assumed wherever current payments are better for the family than modeled future payments under the mandated benefit package. Supplementation amounts are accumulated equal to the difference between current and required benefits. Employer contributions are assumed to cover the supplement, although employer payments for the required coverage are held to the mandated minimum.

The AHSIM Model assumes that both employers and households attempt to hold their spending on health insurance constant from baseline to reform. To the extent that baseline spending on employer-sponsored insurance exceeds expenditures required under reform, employers are first assumed to buy down their employees' required contributions. If baseline spending exceeds reform requirements for either households or employers after taking this transfer into account, the AHSIM model then allows both households and employers to buy supplemental insurance. For each health insurance unit in AHSIM, the actuarial value of supplemental insurance purchased under reform cannot exceed baseline levels. The total amount of supplemental insurance is also limited by the level of potential out-of-pocket expenses (cost-sharing plus noncovered services) under reform. Supplemental insurance is also assumed to carry a higher administrative load than basic health plans, 25 percent in most recent simulations. Any employer excess that remains after buying supplemental insurance is assumed to increase other tax-preferred fringe benefits.

Household spending is defined to be the employee contributions for employer-sponsored health insurance, direct premiums for non-group coverage (under the current system) or direct purchase of alliance coverage (under reform), and cost-sharing payments. In the baseline, the employee contributions are defined to include employee payments irrespective of tax status; pre-tax employee contributions are counted as employee payments despite IRS treatment of such sums as employer contributions. To the extent supplementation implies higher business payments, household spending is reduced by like amounts. Total changes in cost-sharing are calculated as the net of reduced payments due to new and enriched coverage, against increased cost-sharing attributable to required purchase of insurance leading to increased utilization and some personal payments (rather than reliance on uncompensated care mechanisms).

Government spending changes reflect transfers between the Federal government and other levels of government, as well as increased Federal responsibilities (particularly in arranging discounts for low-wage firms). Baseline Federal spending is primarily Medicaid and Medicare. Under reform, Medicaid non-cash populations move into alliance plans, with some direct business payments. Similarly, more Medicare recipients fall under working aged rules, with direct employer contributions reducing Medicare responsibilities.

State and local baseline spending is primarily Medicaid, although significant sums are currently spent on other programs, most notably direct payments to hospitals. Under reform, Medicaid savings will be redirected under maintenance of effort requirements for use in paying for discounts for low-income populations in the alliances.

References

Burner, S. and D. Waldo. "Using HCFA's Special Policy Analysis Model to Simulate Benefits in a Health Reform Scenario". Health Care Financing Administration Internal Memorandum, March 1993.

Doyle, P. "Microsimulation and Health Care Reform." Proceedings of the American Statistical Association 1993 Annual Conference. Alexandria, VA: American Statistical Association, 1993.

Giannarelli, L. (1992). An Analysts' Guide to TRIM2. Washington, D.C.: The Urban Institute Press.

Holahan, J. and S. Zedlewski. (1989). Insuring Low-Income Americans Through Medicaid Expansion. Washington, D.C.: The Urban Institute.

Lewis, G. and R. Michel. (1990). Microsimulation Techniques for Tax and Transfer Analysis. Washington, D.C.: The Urban Institute Press.

National Research Council. (1991). Improving Information for Social Policy Decisions. Washington, D.C.: National Academy Press.

Wade, M. (1991). "Out-of-Pocket Expenditure Model (revised). Urban Institute Research Memorandum. (October).

Zedlewski, S., J. Holahan, L. Blumberg, and C. Winterbottom (1993). "The Distributional Effects of Alternative Health Care Financing Options," Washington, D.C.: The Urban Institute.

Zedlewski, S.R. (1991). Expanding the employer-Provided Health Insurance System: Effects on Workers and Their Employers. Urban Institute Report 91-3. Washington, D.C.: The Urban Institute.

APPENDIX A

Example of the Application of an Induction Factor To a Change in Insurance Status

	Before Change	After Change
Current law spending	\$200	\$200
Multiplied by copayment rate	<u>x 50%</u>	<u>x 20%</u>
Out-of-pocket spending	\$100	\$40
Initial change in out-of-pocket		\$60
Multiplied by induction factor		<u>x 0.7</u>
Equals change in total spending		\$42
Current law spending		\$200
Plus induced demand		<u>42</u>
Equals new total spending		242
Less new out-of-pocket (20%)		<u>- 48</u>
Equals new benefits		194

Induction Factors Used in SPAM Simulations

Hospital inpatient (facility and physician)	0.3
Prescription drugs	1.0
Emergency room services and DME	0.0
All other services	0.7

SOURCE: Office of the Actuary
Health Care Financing Administration