06-Sep-93

DETAIL OF SUBSIDY COSTS

(billions of dollars)

Fiscal Years	1994	1995	1996	1997	1998	1999	2000	1994-00
Subsidies Net of Offset	0	5	25	33	34	33	30	160
Gross Subsidies	0	14	58	80	86	89	92	419
Total Offsets	0	-9	-33	-47	-52	-56	-62	-259
State Offset for Medicaid in Alliance	0	-3	-10	-14	-15	-15	-16	-73
Federal Offset for Medicaid in Alliance	0	-4	-15	-22	-25	-28	-31	-125
Federal Offset for Medicare in Alliance	0	-2	-8	-11	-12	-13	-15	-61

* Estimates are preliminary and do not incorporate interactive effects.

DRAFT

COMPARISON OF PREMIUM SUBSIDIES UNDER THREE HEALTH REFORM PROPOSALS

Prepared for:

THE KAISER COMMISSION ON THE FUTURE OF MEDICAID

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Thank you very much,
Jen! Mayer

Introduction

One of the main issues in the current debate over health reform is how to extend health insurance coverage to those individuals who are not currently covered. One basic approach to covering the uninsured is to use government subsidies to reduce the cost of insurance premiums to encourage uninsured individuals to purchase insurance. Currently, many of the uninsured are low-income individuals and the full cost of insurance can take up a large share -- perhaps 30 or 40 percent -- of their income. For these individuals, the trade-off between buying health insurance can be food, rent, winter clothing or other essentials.

Several recent legislative proposals have addressed this affordability problem through the use of government subsidies. This paper summarizes three alternative health reform bills -- H.R. 3222 (Cooper/Breaux), H.R. 3704 (Thomas/Chafee) and H.R. 3600 (President Clinton) -- which each take somewhat different approaches to covering the uninsured and providing subsidies. The Cooper/Breaux Bill seeks to achieve greater insurance coverage by reducing the cost of insurance to low-income individuals through the use of government premium subsidies. The Bill would not require individuals to purchase insurance, nor does it require an employer contribution, but instead relies on a price incentive to encourage individuals to purchase insurance. By contrast, the Chafee/Thomas Bill requires individuals to purchase insurance and provides for premium subsidies in order to make the cost of insurance more affordable for low- income individuals. The Chafee/Thomas Bill does not require employers to contribute toward the insurance premium cost. Like the Chafee/Thomas Bill, the Administration's proposal seeks to achieve universal coverage through a mandate that requires individuals to purchase insurance. The Bill also provides for subsidies to reduce the burden on low income households. Under the Bill, employers are required to contribute 80 percent of the cost of insurance, although workers ultimately pay this price as well. Recognizing that the ultimate impact of the employer mandate is on workers, the Bill also provides subsidies to small businesses with low average payrolls.

Our basic analysis focusses on how each of the three bill would reduce the net cost of insurance -- the cost of insurance premiums less government subsidies. Specifically, we assess the impact of each bill's premium subsidies on the net cost of insurance under a common set of insurance

Table 1. Net Premium as a Percent of Family Income 1/
(Employee Bears Employer Premium)

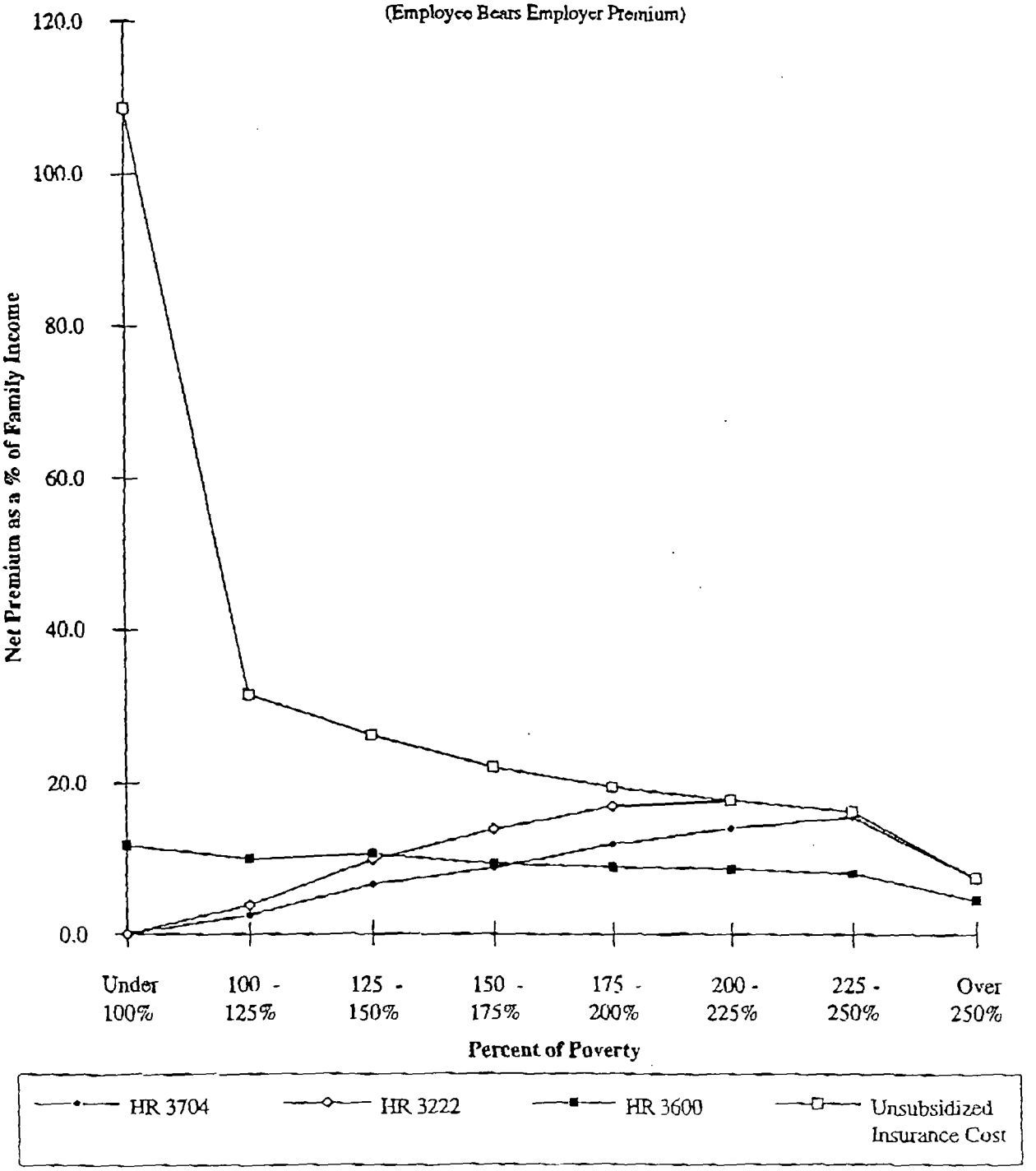
Percent of Poverty	Policy Units Whose Earner(s) are Self-Employed or Not Employed Full-Time				Policy Units Whose Earner(s) Work Full-Time, But With No Current Employer Contribution				Persons With Full Time Job, With Current Employer Contribution			
	H.R. 3704	H.R. 3222	H.R. 3600	Total Premium as a Percent of Family Income	H.R. 3704	H.R. 3222	H.R. 3600	Total Premium as a Percent of Family Income	H.R. 3704	H.R. 3222	H.R. 3600	Total Premium as a Percent of Family Income
Under 100%	0.0%	0.0%	11.7%	108.7%	0.0%	0.0%	26.4%	55%	36.7%	36.7%	25.5%	51.9%
100 - 125%	2.5	3.8	10.0	31.6	2.8	4.2	19.1	34.0	25.2	29.3	20.5	33.3
125 - 150%	6.5	9.9	10.6	26.2	6.8	10.1	17.2	27.3	20.3	26.4	17.3	26.8
150 - 175%	8.8	13.9	9.2	22.1	10.1	14.7	15.8	23.5	17.9	23.0	16.3	23.0
175 - 200%	11.9	17.0	8.9	19.5	12.7	18.3	14.5	21.0	16.0	20.2	15.0	20.2
200 - 225%	14.0	17.8	8.7	17.8	14.3	18.3	13.3	18.3	14.6	17.8	13.9	17.8
225 - 250%	15.5	16.2	7.9	16.2	16.1	16.8	12.4	16.8	15.6	16.2	12.9	16.2
Over 250%	7.3	7.4	4.4	7.4	8.4	8.5	6.8	8.5	7.7	7.7	7.0	7.7
Total	7.0	7.8	6.5	22.8	8.8	9.7	9.7	13.9	8.5	8.7	7.7	8.8

1/ In this long-run analysis, the employer share of the premium (net of any subsidy) has been assigned to families as part of the economic cost of health insurance. In the long-run, we would expect workers to bear a high percentage of the employer's cost, net of employer subsidies.

Figure 1. Net Cost of Insurance, by Poverty Level Class

Policy Units Whose Earner(s) are Self-Employed or Not Employed Full-Time

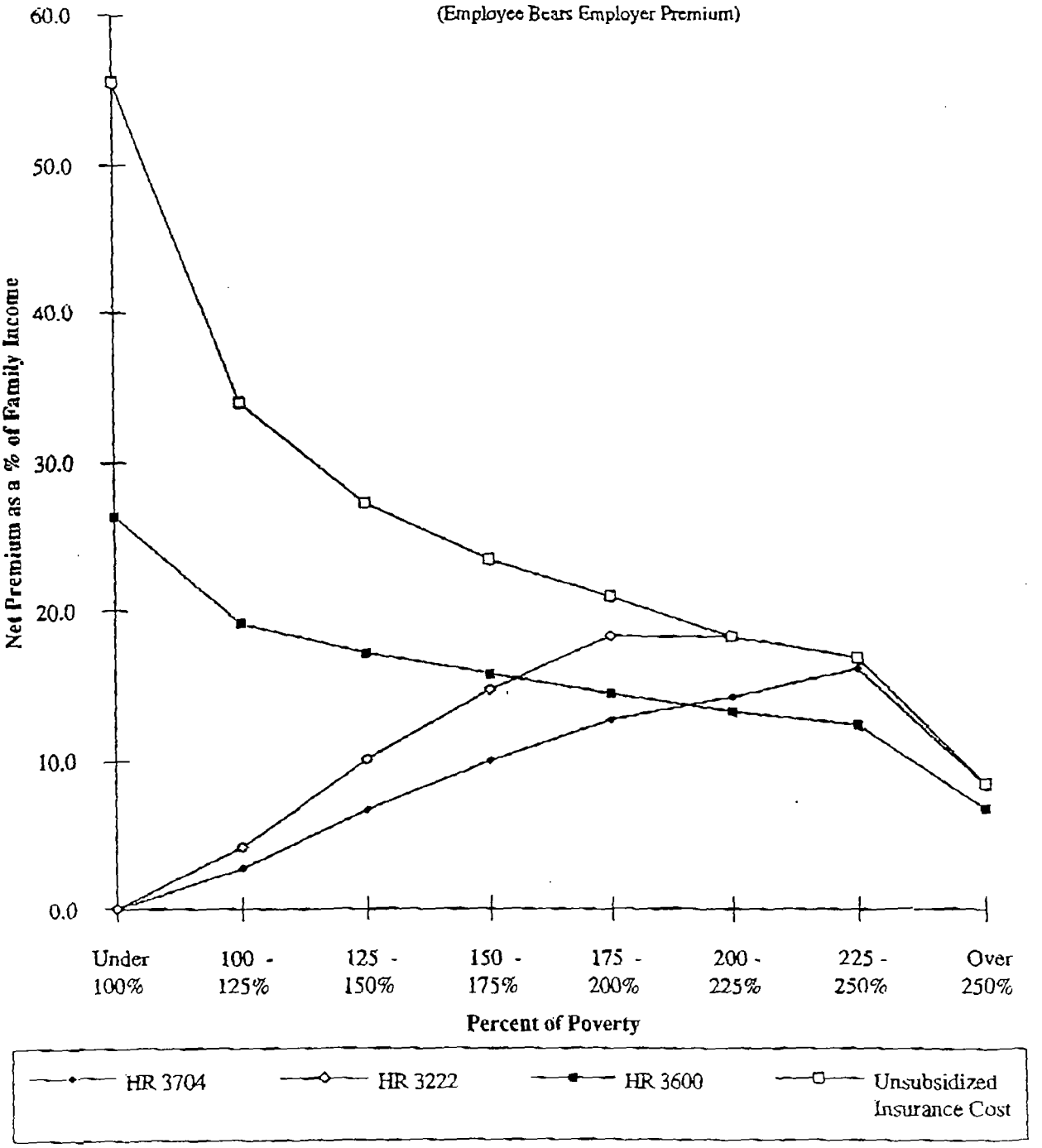
(Employee Bears Employer Premium)



Note: Net cost of insurance equals insurance premiums less subsidies, as a percentage of income.

Figure 2. Net Cost of Insurance, by Poverty Level Class

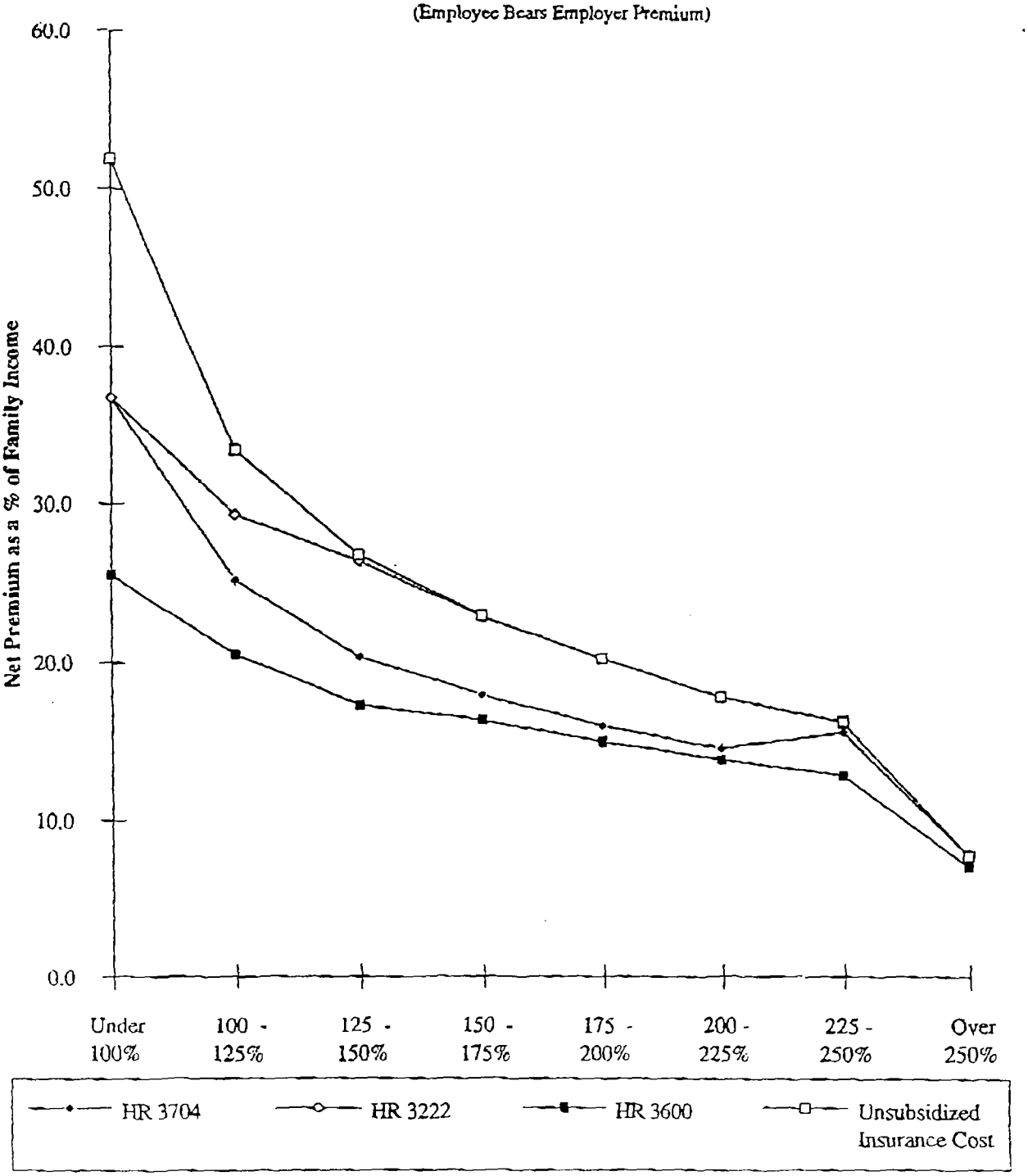
(Policy Units Whose Earners(s) Work Full-Time, But With No Current Employer Contribution)



Note: Net cost of insurance equals insurance premiums less subsidies, as a percentage of income.

Figure 3. Net Cost of Insurance, by Poverty Level Class

(Persons With Full Time Job, With Current Employer Contribution)
(Employee Bears Employer Premium)



Note: Net cost of insurance equals insurance premiums less subsidies, as a percentage of income.

proposals (net of any family or employer subsidies), and the cost of insurance with no subsidy. Thus, the difference between the unsubsidized cost and the cost under a specific policy proposal indicates the degree to which that proposal's subsidies reduce the cost of insurance. The percentages reflect the cost to the average family (as a percentage of income) in each poverty level class, assuming the family opts for health insurance coverage.

Families with self-employed or no full-time workers -- Under H.R. 3704 (Chafee) the net cost of health insurance is zero for families in poverty, rising to 16 percent of income at 225-250 percent of poverty. Under H.R. 3222 (Cooper), the net cost of insurance is also zero for families under the poverty line and rises to 18 percent of income at 200-225 percent of poverty. H.R. 3600 shows a much different pattern, with the cost of insurance running from 12 percent of income for families below the poverty line down to 4 percent of income for families at over 250 percent of poverty. The net cost is higher under H.R. 3600 because the Bill requires some premium payment by families with incomes between $1,000 and the poverty line, whereas H.R. 3704 and H.R. 3222 do not. Also, for those who work part-time, employers are required to pay a partial premium (after subsidy) that is assumed to be borne by the worker. Overall, for families with no full-time worker, H.R. 3704 and H.R. 3222 are more generous than H.R. 3600 which requires employer contributions (that are ultimately borne by employees).

Families with a full time worker (no employer contribution) -- For families with no employer contribution (under the Cooper and Chafee bills), the subsidy pattern is much the same as above. Under H.R. 3704 the net cost of health insurance is zero for families with incomes below the poverty line, rising to 16 percent of income at 225-250 percent of poverty; under H.R. 3222 the net cost is zero for families with incomes under the poverty line and is 17 percent of income at 225-250 percent of poverty. H.R. 3600 imposes a net insurance cost of about 26 percent of income for families in poverty and declines to 7 percent for policy units over 250 percent of poverty. The relatively high cost for the working poor under H.R. 3600 is the result of the mandated employer premium (net of employer subsidy) that is borne by workers. This cost is higher than the cost for families whose earners are part-time because employers must pay a full employer share (net of subsidy) rather than the partial share they owe for part-time workers. The net insurance cost under both H.R. 3704 and H.R. 3222 for low-income families is lower than under H.R. 3600 because of their more generous subsidy schedules for low-income families and because the employer is not required to contribute to the health insurance plan.

Families with a full time worker (with employer contribution) -- For families that currently receive an employer contribution (assumed to be 80 percent), the subsidy pattern is much different. The net cost of health insurance under H.R. 3704 and H.R. 3222 is 37 percent for families in poverty compared to 26 percent under H.R. 3600. Although

families receive 100 percent subsidies under H.R. 3704 and H.R. 3222 for their share, the employer's share is not subsidized.[2] By contrast, H.R. 3600 includes a significant employer subsidy component that reduces the cost of insurance for lower-income families. As incomes increase, the cost differentials between the proposals decline. At 200-225 percent of poverty, the net cost is about 16 percent for both H.R. 3704 and H.R. 3222, and is 13 percent for the H.R. 3600. For income classes over 250 percent of poverty, the cost of insurance is about 9 percent under both H.R. 3704 and H.R. 3222, and is 8 percent under H.R. 3600. At higher levels of income, subsidies to families are phased-out under all three proposals, although under the Administration's proposal, employer subsidies may still be paid on the behalf of higher income workers. Because the employer subsidies under H.R. 3600 are not directly tied to the income of specific workers, high wage employees in low-wage or small firms may still receive the benefit of the Bill's employer subsidies. Overall, where the employer contributes 80 percent, the net insurance cost under H.R. 3600 is less than under either of the alternative proposals.

Overall, all three health reform proposals provide subsidies that would significantly reduce the cost of health insurance for low-income individuals. The Administration's proposal does tend to place a heavier burden on those who would not otherwise receive an employer contribution because of its employer mandate. The net cost of insurance is lower under the Administration's proposal for those who currently receive an employer contribution because neither the Cooper nor Chafee proposals provide explicit proposals for employer subsidies,

Employees Do Not Bear the Cost of Employer Contributions

In Table 2 and in Figures 4 to 6, we show the net cost of health insurance based on the alternative assumption that employees do not bear the economic cost of employer contributions made on their behalf. Thus, for each type of policy unit, the net cost of insurance for each of the three health reform proposals is the premium (net of subsidy) that the family pays out of pocket. The difference between the unsubsidized cost and the cost under a specific policy proposal indicates the degree to which that proposal's subsidies reduce the cost of insurance. The employer's share (if any) is implicitly treated as a subsidy to the family for the purchase of

[2] For the purposes of this analysis, we exclude the indirect subsidy provided through the tax system that allows individuals to exclude employer-paid premiums from their taxable incomes.

Table 2. Net Premium as a Percent of Family Income 1/
(Employee Does Not Bear Employer Premium)

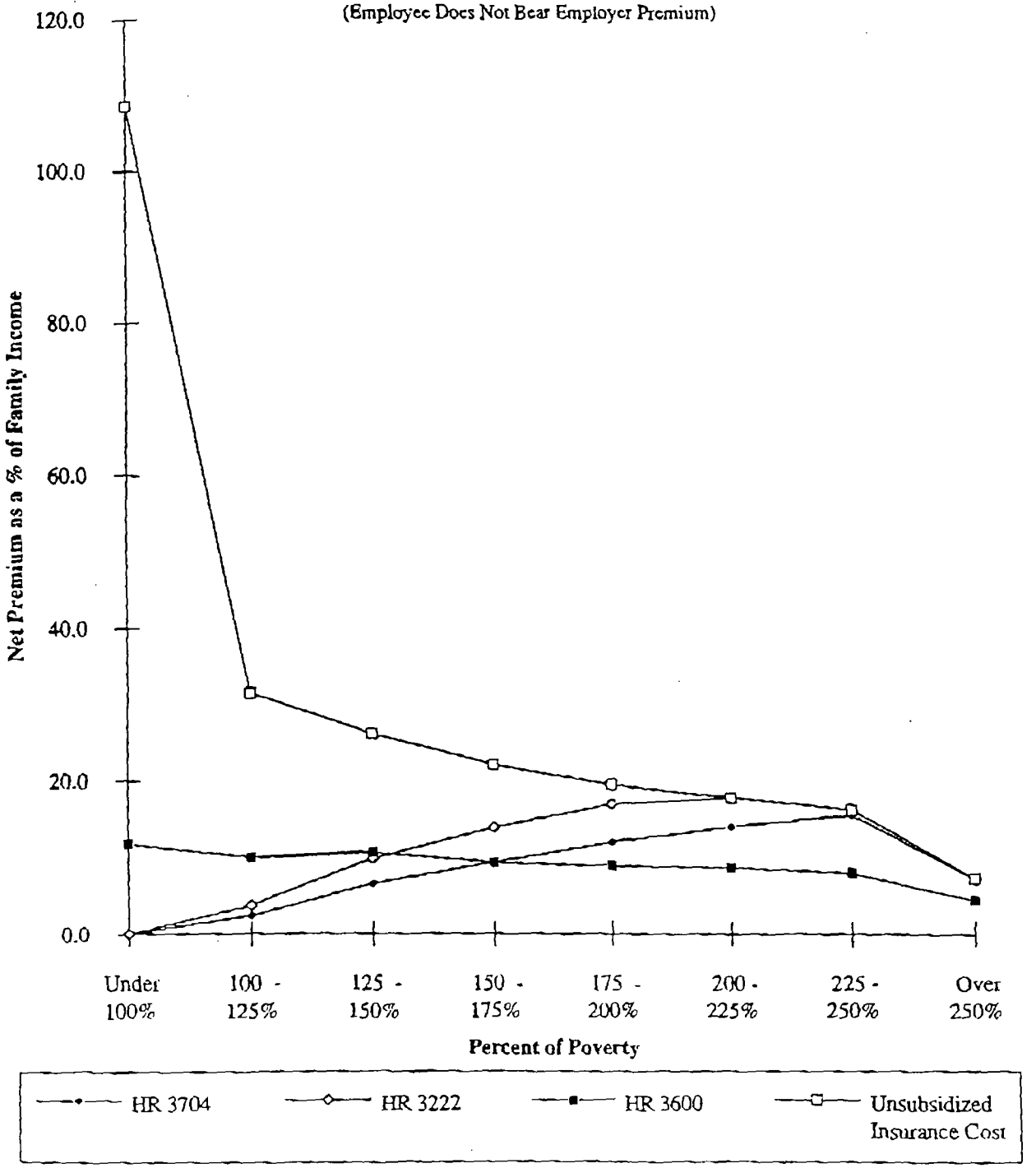
Percent of Poverty	Policy Units Whose Earner(s) are Self-Employed or Not Employed Full-Time				Policy Units Whose Earner(s) Work Full-Time, But With No Current Employer Contribution				Persons With Full Time Job, With Current Employer Contribution			
	H.R. 3704	H.R. 3222	H.R. 3600	Total Premium as a Percent of Family Income	H.R. 3704	H.R. 3222	H.R. 3600	Total Premium as a Percent of Family Income	H.R. 3704	H.R. 3222	H.R. 3600	Total Premium as a Percent of Family Income
Under 100%	0.0%	0.0%	3.7%	108.7%	0.0%	0.0%	2.9%	55.5%	0.0%	0.0%	3.1%	51.9%
100 - 125%	2.5	3.8	5.2	31.6	2.8	4.2	3.6	34.0	0.0	4.1	3.7	33.3
125 - 150%	6.5	9.9	6.2	26.2	6.8	10.1	3.9	27.3	0.0	6.1	4.0	26.8
150 - 175%	9.4	13.9	6.2	22.1	10.1	14.7	3.8	23.5	0.0	5.1	3.9	23.0
175 - 200%	11.9	17.0	6.7	19.5	12.7	18.3	3.7	21.0	0.2	4.4	3.7	20.2
200 - 225%	14.0	17.8	6.6	17.8	14.3	18.3	3.4	18.3	0.6	3.8	3.4	17.8
225 - 250%	15.5	16.2	6.2	16.2	16.1	16.8	3.3	16.8	2.8	3.4	3.2	16.2
Over 250%	7.3	7.4	3.8	7.4	8.4	8.5	1.7	8.5	1.6	1.6	1.5	7.7
Total	7.0	7.8	4.4	22.8	8.8	9.7	2.2	13.9	1.5	1.8	1.7	8.8

1/ In this long-run analysis, the employer share of the premium (net of any subsidy) has been assigned to families as part of the economic cost of health insurance. In the long-run, we would expect workers to bear a high percentage of the employer's cost, net of employer subsidies.

Figure 4. Net Cost of Insurance, by Poverty Level Class

(Policy Units Whose Earners(s) are Self-Employed or Not Employed Full-Time)

(Employee Does Not Bear Employer Premium)

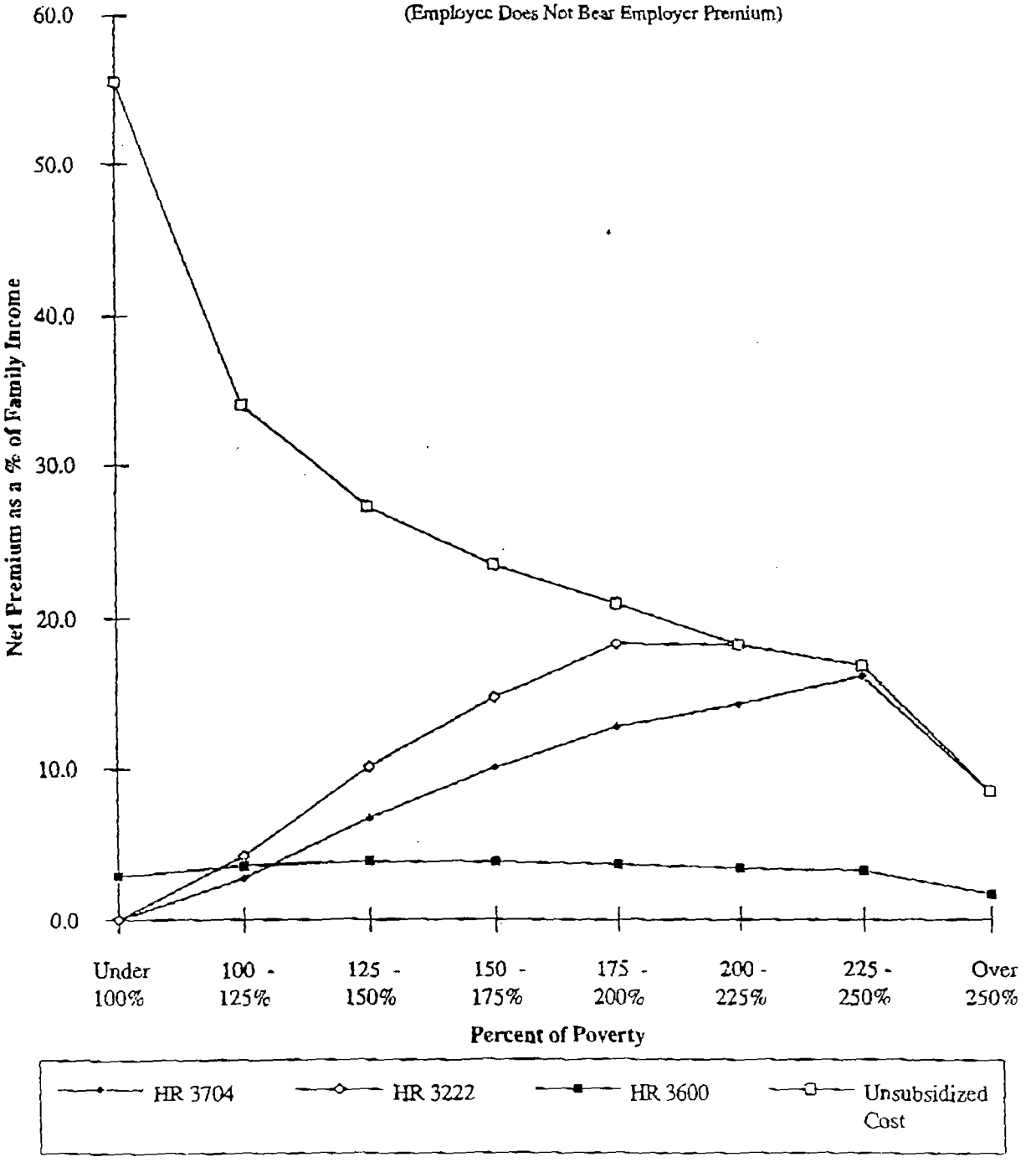


Note: Net cost of insurance equals insurance premiums less subsidies, as a percentage of income

Figure 5. Net Cost of Insurance, by Poverty Level Class

(Policy Units Whose Earners(s) Work Full-Time, But With No Current Employer Contribution)

(Employee Does Not Bear Employer Premium)

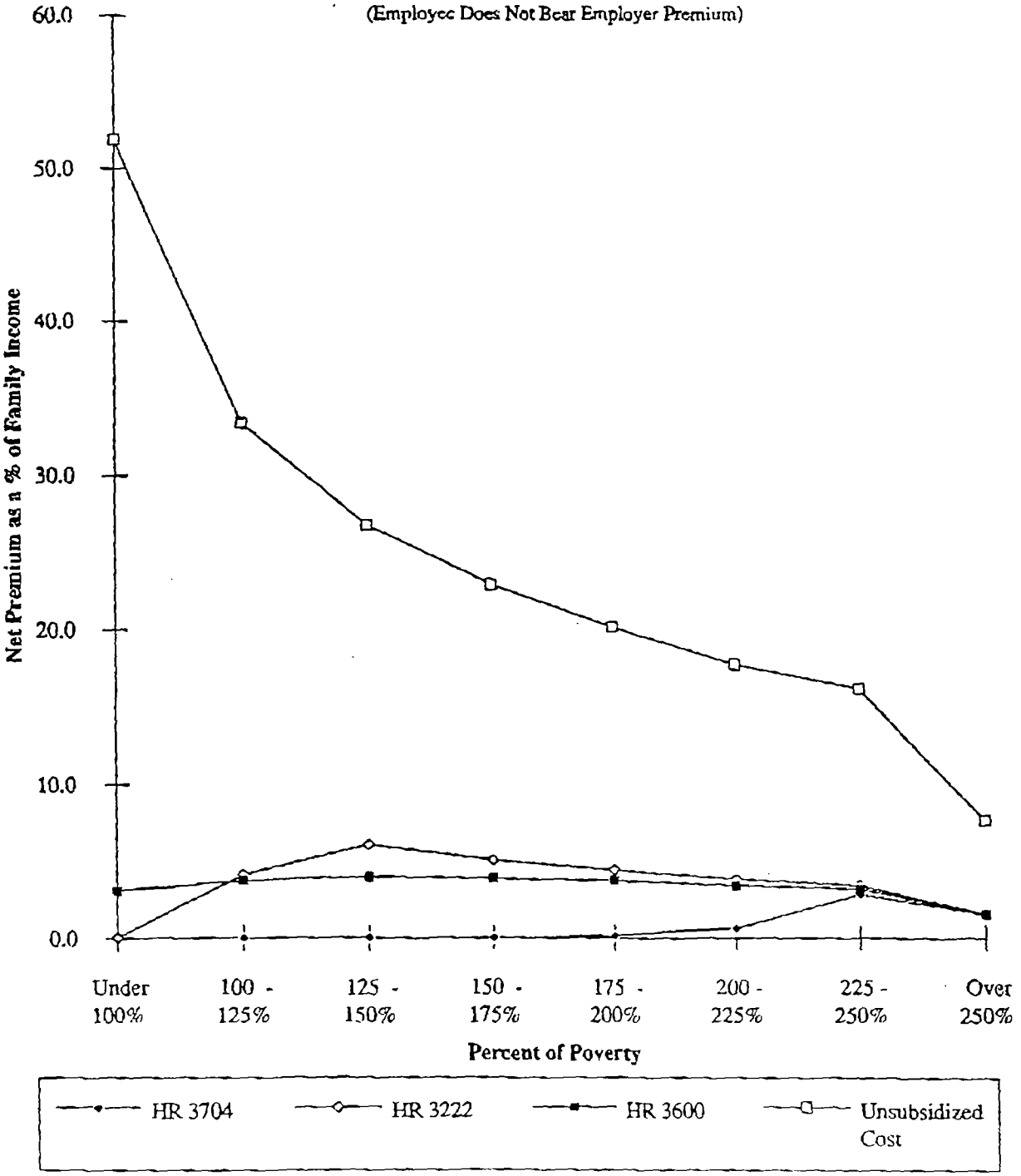


Note: Net cost of insurance equals insurance premiums less subsidies, as a percentage of income.

Figure 6. Net Cost of Insurance, by Poverty Level Class

(Persons With Full Time Job, With Current Employer Contribution)

(Employee Does Not Bear Employer Premium)



Note: Net cost of insurance equals insurance premiums less subsidies, as a percentage of income.

health insurance. As in Table 1, the percentages in Table 2 reflect the cost to the average family in each poverty level class (as a percentage of income), assuming the family opts for health insurance coverage.

Families with self-employed or no full-time workers -- Under H.R. 3704 the net cost of health insurance is zero percent for families in poverty, rising to about 16 percent of income at 225-250 percent of poverty. Under H.R. 3222, the net cost of insurance is zero percent for families under the poverty line and rises to 18 percent of income at 200-225 percent of poverty. H.R. 3600 shows a much different pattern, with the cost of insurance running from 4 percent of income for families below the poverty line to about 7 percent of income for families at 175-200 percent of poverty. For policy units with incomes below the poverty line, H.R. 3600 imposes a higher cost because it requires some premium payment by families with incomes between $1,000 and the poverty line, whereas H.R. 3704 and H.R. 3222 do not. For policy units with income over the poverty line, H.R. 3600 generally imposes a lower cost because it caps the family premium share at 3.9 percent of income for those with incomes under $40,000. (In the Table, the percentages are somewhat higher than 3.9 percent because part-time workers and the self-employed are required to pay an additional premium amount that represents some portion of the "unpaid" employer share.) Overall, under the assumption that employees do not bear the employer contribution, families with no full-time worker (with incomes over the poverty line) have a lower net insurance cost under H.R. 3600 than under either H.R. 3704 or H.R. 3222.

Families with a full time worker (no employer contribution) -- For families with no employer contribution (under the Cooper and Chafee bills), the subsidy pattern is much the same as above. Under H.R. 3704 the net cost of health insurance is zero percent for families with incomes below the poverty line, rising to 16 percent of income at 225-250 percent of poverty; under H.R. 3222 the net cost is zero percent for families with incomes under the poverty line and is 18 percent of income at 175-225 percent of poverty. H.R. 3600 imposes a cost of about 3 percent of income for families in poverty and remains in the range of 3-to-4 percent between 100 and 225 percent of poverty. Again, this lower cost under H.R. 3600 is because it caps the family premium share at 3.9 percent of income for those with incomes under $40,000

Families with a full time worker (with employer contribution) -- For families who receive an employer contribution, the subsidy pattern is much different. The net cost of health insurance under H.R. 3704 is zero percent for families in poverty and remains at about zero percent for families up to 200 percent of poverty. At 225-250 percent of poverty, the net cost is 2.8 percent of family income. The primary reason for this effect is that the employer contribution augments the premium subsidy provided under H.R. 3704. Under H.R. 3222 the net cost is zero percent for families under the poverty line and rises to 6 percent of income for families with income in the 125-150 percent of

poverty range. The cost declines steadily thereafter. The net cost under H.R. 3600 is 3 percent of income for families in poverty, and is in the 3-to-4 percent range for families with income between 100 and 225 percent of poverty. Thus, where the employer contributes 80 percent, the net cost under H.R. 3704 is less than under either of the alternative proposals.

The results in Table 2 indicate that, when the employer's contribution is treated like a subsidy, H.R. 3600 tends to have the more generous premium subsidies when the employer does not contribute to the policy costs. Under both H.R. 3222 and H.R. 3704 employer contributions to heath insurance remain voluntary. For workers whose employer contributes 80 percent of the insurance cost, H.R. 3704 provides more generous premium subsidies for low income individuals. This conclusion is somewhat tentative as it depends on our interpretation of the subsidy language of H.R. 3704 as to whether the subsidy percentage in the Bill applies to the full insurance premium (as we assume) or just the family's premium share (after employer contribution).

Who Pays for Employer Health Insurance Contributions?

In the long run, we assume that employees bear the true cost of any employer health insurance contributions made on their behalf. Our results rest very heavily on this assumption and it is subject to considerable debate. This assumption is justified in a competitive labor market in which firms must compensate (in cash and fringe benefits) employees based on their value to the firm's output. If a firm pays an employee more than his or her value, the firm will not remain in business for long. Conversely, if a firm pays an employee less than his or her value, the firm is likely to lose that employee to another firm that will pay the employee their full value. In determining the labor cost of an employee, firms look at the total compensation package and often negotiate individually or with unions as to the mix of cash and fringes to be paid. In the case where fringe benefits are increased -- either voluntarily or by mandate -- the level of wages paid in the form of cash must decrease. If a firm attempts to pay total compensation in excess of the value of its product -- a value that is unchanged -- the firm will lose money and eventually go bankrupt. In the long-run, only those firms that adequately adjust their total compensation package can remain in business.

The cost to employees of increased health insurance contributions may be borne in the form of lower wages, reduced raises or loss of employment. The potential for job loss is greatest for workers who hold minimum (or near minimum) wage jobs and for which the employer share of the premium is a sizable percentage of total labor compensation.

Increased health insurance costs may also be passed along by businesses to consumers in the form of higher prices. In this case, nominal wages may remain unchanged, but real wages reduced as a result of higher prices. The distributional impact is less clear in this case because its effect would come in the form of lower real incomes resulting from higher prices. Moreover, to the degree that government transfer programs are indexed, the impact of the rise in prices on recipients may be somewhat tempered.

Tax Code Provisions

This analysis of premium subsidies does not take into account the Tax Code provisions specified in each Bill. Under current tax law, employer contributions are excluded from the taxable income of employees and family premiums are allowed as an itemized deduction (subject to the 7.5 percent AGI limitation on medical expenses). These provisions provide an implicit subsidy that may significantly reduce the cost of health insurance for upper income individuals in high tax brackets. The Administration's proposal retains these basic provisions and extends the deduction for the self-employed to 100 percent (from its current level of 25 percent). The Cooper proposal retains a limited exclusion for employer premium contributions and expands the deduction for premiums by individuals by allowing a full deduction against AGI. The Chafee proposal also retains a limited exclusion for employer premium contributions and allows individual premiums as a deduction against AGI. These provisions are outside the scope of the current analysis, but each affect the net after-tax cost of health insurance, certainly for higher income taxpayers.

Subsidy Provisions

The subsidy provisions of each bill are briefly summarized as follows:

H.R. 3704. Families with incomes below the poverty line are provided a 100 percent subsidy of their premiums. A sliding scale of subsidies is provided for families with income between 100 and 240 percent of poverty. For example, a family with income at 170 percent of poverty would receive a subsidy equal to 50 percent of the premium. This scale is phased in over time and is not fully effective until 2005. Employers receive no subsidy for their share (if any) of insurance premiums. In the case where employers contribute to the insurance premium, we assume that the subsidy to families is not affected. Thus, if an employer contributes 80 percent of the premium and the family is eligible for a 20 percent subsidy, the family's own premium would be reduced to zero. This assumption is based on our reading of the Bill, although the language is unclear as to whether the subsidy percentage applies to the full insurance premium (as we assume) or just the family's premium share. If the 20 percent subsidy percentage applied simply to the family share, the family's net premium percentage would be reduced to 16 percent.[3]

H.R. 3222. Families with incomes below the poverty line are provided a 100 percent subsidy of their premiums. A sliding scale of subsidies is provided for families with incomes between 100 and 200 percent of poverty. For example, a family with income at 150 percent of poverty would receive a subsidy equal to 50 percent of the premium. Employers receive no subsidy for there share (if any) of insurance premiums. In the case where employers contribute to the insurance premium, the subsidy to families is reduced proportionately. Thus, if an employer contributes 80 percent of the premium and the family was eligible for a 50 percent subsidy, the family's own premium would be reduced to 10 percent of the full policy cost.

H.R. 3600. Families with incomes under $1,000 (indexed) receive a full 100 percent subsidy of their share of the insurance premium. For families with incomes between $1,000 and 100 percent of poverty, a sliding subsidy scale is used to limit the after-subsidy cost of insurance to zero percent at $1,000 of income increasing to 3 percent of income at 100 percent of poverty. Between 100 and 150 percent of poverty, a sliding subsidy scale is also used that limits the cost of insurance to 3.0 percent at 100 percent of poverty increasing to 3.9 percent of income at 150 percent of poverty. Subsidies are also provided in order to reduce the cost of insurance to 3.9 percent of income for all other families with incomes under $40,000 (indexed).

H.R. 3600 mandates that employers pay 80 percent of the cost of insurance. In general, subsidies under the Bill are designed to limit the net cost of insurance (paid by all firms) to 7.9 percent of payroll, assuming the firm joins a regional alliance. The net insurance cost is further limited for small firms and those with low average wages. As a percentage

[3] 16 percent = 20 percent x (1.0 - 0.2)

of payroll, the net cost of insurance is reduced to between 3.5 percent (firms with under 25 employees and average payroll under $12,000) and 7.9 percent.[4]

Detailed Results

In this section we report the detailed results from our analysis of the premium subsidies for each of the three health care reform proposals. For each proposal, we show the results for three separate groups of families depending on the employment status of the parents. Tables 3 through 11 show the distribution of premium subsidies under each health reform bill. The tables show each family type under two alternative assumptions: (1) that the employee bears the economic cost of the employer's premium, and (2) that the employee does not bear the economic cost of the employer's premium. In general, we view the long run impact of employer contributions to health insurance -- or any other fringe benefit -- as being ultimately borne by the employee. In the short-run, employers may not be able to shift the cost of increased health insurance contributions to employees and the latter assumption may be more consistent with the short run impact of changes in employer health insurance contributions.

In the tables we report the cost of insurance for policy units based on their income relative to the poverty standard used by the Bureau of the Census. The poverty standard is based on the size and composition of the policy unit. For reference, we estimate the poverty standard for a single individual in 1998 to be $8,715; for a married couple we estimate it to be $11,384; for a single parent with two children we estimate it to be $13,497; and for a married couple with two children we estimate it to be $16,988.

Premium Subsidies Under H.R. 3222 (Cooper)

[4] The net cost is reduced to below 7.9 percent for (1) firms with less than 25 employees and average payroll under $24,000; (2) firms with 25 to 50 employees and average payroll under $21,000; and (3) firms with 50 to 75 employees and average payroll under $18,000.

Tables 3 through 5 show our calculations of the premium subsidies under HR 3222. The three tables are intended to illustrate families in three different circumstances. Table 3 shows premiums and subsidies for families whose workers are self-employed or who do not work full-time.[5] Table 4 shows families with at least one full-time equivalent employee, but whose employer does not currently contribute to a health insurance plan. (This definition includes those individuals who have an employer-sponsored health plan to which the employer does not contribute.) Table 5 shows the results for families with at least one full-time equivalent employee whose employer does contribute to a health insurance plan.

In Table 3, we show the premium subsidies where the family does not have a full-time employee and must pay the full premium. Because the Bill does not mandate insurance coverage, the premiums and subsidies are the average amounts that individuals would pay if they were to elect insurance coverage under HR 3222. The average insurance premium at each poverty level reflects the average insurance cost for the families in each poverty category. Because the premiums vary depending on the composition of the families (singles, couples, single-parent families, two-parent families) in each group, average premiums tend to vary somewhat across poverty categories.

As shown in Table 3, the subsidy is 100 percent of the premium for families with income below 100 percent of poverty. (Although the Cooper bill refers to individual state poverty levels, we have used the Federal poverty level in the tables.) The premium subsidy (as a percent of the total premium) declines steadily to zero percent when family income exceeds 200 percent of poverty. As a percent of family income, the net cost of the insurance coverage rises from zero percent for those with incomes below 100 percent of poverty to a maximum of about 18 percent at 200-225 percent of poverty. For those families between 150 and 200 percent of poverty, the net cost of insurance will exceed 10 percent of family income. Because the Cooper Bill retains the option of turning down insurance coverage, we would expect many families in this income

[5] Technically, a full time worker (or equivalent) can be either one full time (27 hrs/wk) worker or two part-time workers whose combined weekly hours exceed 27 hours.

range to decline coverage because of its expense. Because there is no employer premium in this case, there is no difference in the cost depending on who bears the employer premium.

The results for H.R. 3222 in Table 4 are very similar to those shown in Table 3. This similarity is due to the fact that in both sets of tables there is no employer contribution. Therefore, for individuals who elect coverage, the individual (and family) must bear the entire cost of insurance coverage. In both Tables 3 and 4, the cost to the individual (as a percentage of income) is greatest (about 18 percent) when subsidy phases down to zero at 200 percent of poverty.

Table 5 shows a policy unit with an employed person where we have assumed the employer pays 80 percent of the premium and the family pays the remainder. Where the employee does not bear the cost of the employer contribution (the contribution is treated like an added subsidy), the cost of insurance appears much less, ranging from zero percent for those policy units with incomes below the poverty line to about 4 percent at 175-200 percent of poverty. By contrast, where the employee bears the cost of the employer contribution, we show the net cost of the premium to be 37 percent for those individuals below the poverty line. The net cost of insurance declines from 29 percent at 100-125 percent of poverty to 16 percent at 225-250 percent of poverty. These high percentages show that for these individuals, the cost of health insurance (for those who opt for coverage) would be a large share of total compensation under the Cooper proposal.

Premium Subsidies Under H.R. 3704 (Chafee)

Tables 6 through 8 show our similar calculations of the premium subsidies under HR 3704.

In Table 6, we show the subsidies for families with self-employed or no full-time employees. Again, the subsidy is 100 percent of the premium for families with income below 100 percent of poverty. Under the Chafee bill, the premium subsidy schedule is more generous and extends over a longer income range (up to 240 percent of poverty) than H.R. 3222 (the Cooper Bill). (In our analysis we have assumed the Chafee bill is fully phased in although the subsidy schedule

does not take full effect until 2005.) In the 200-225 percent of poverty range, individuals are still receiving a subsidy of about 21 percent of their premium. Because of its more generous subsidies, the net cost of insurance (premium less subsidy) as a percent of family income is somewhat less under the Chafee Bill than under the Cooper Bill. For example, the maximum cost (as a percentage of income) is 15 percent under the Chafee Bill (for incomes between 225 percent and 250 percent of poverty), and is 18 percent (for the 200-225 percent of poverty class) under the Cooper bill (See Table 3).

The subsidies for families with a full time worker (but no employer contribution) are shown in Table 7. The results are quite similar to those in Table 6, primarily because we have assumed no employer premium contribution. Under H.R. 3704 insurance coverage is mandated, but employer contributions remain voluntary.

In Table 8, we show the premium subsidies for workers whose employer contributes 80 percent of the premium amount. Under the assumption that employees do not bear the employer's contribution, the net cost to the family of insurance is zero up to 212 percent of poverty. At 212 percent of poverty the family's subsidy percentage is 20 percent and the employer is assumed to pay 80 percent.

Under the assumption that employees do bear the employer's contribution, the net cost is 37 percent for those families in poverty. The cost is 25 percent for those with incomes between 100 and 125 of poverty, and declines to 16 percent at 225-250 percent of poverty.

The premium subsidy and the net cost of insurance is the same under the Chafee proposal as under the Cooper Bill for insurance policy units with incomes under 100 percent of poverty. For policy units with incomes between 100 percent and 250 percent of poverty, we show a larger subsidy and lower net cost to individuals under the Chafee Bill because the schedule of subsidies is more generous in its level and it extends further up the income scale than the Cooper proposal. As shown in Table 8, the full 100 percent family subsidy extends to about 212 percent of poverty

because the 80 percent employer contribution acts to augment the ordinary subsidy provided by the in the bill.

Premium Subsidies Under H.R. 3600 (Health Security Act)

Tables 9 through 11 show our subsidy calculations under the proposed Health Security Act.

Table 9 shows the premium subsidies for families whose earners are self-employed or who do not work full-time. Under the Health Security Act, employers are required to make a partial contribution for employees who work part-time. Families may be responsible for some share of the "unpaid" portion of the full employer's premium share. This additional family contribution is based on the nonwage income of the policy unit. The Act requires that policy units with nonwage income in excess of 250 percent of poverty pay the full employer share (less any amount paid by the employer for part-time work). For families with income below the poverty line, the Act limits the additional family contribution to less than 5.5 percent of nonwage income, with no additional premium for families with nonwage income under $1,000. Families whose earners are self-employed are also responsible for a share of the "employer's" premium amount. These additional premiums are limited based on the schedule of subsidies provided small businesses with employment of less than 25. For example, an individual with self-employment income under $12,000 would have the additional premium limited to 3.5 percent of self-employment income.

In Table 9, the employee is assumed to bear the cost of the in lieu employer premiums and they are included with the family premium amounts. We show a modest "employer" contribution because the Bill requires prorated employer contributions for the part-time employees who work an average of 9 hours or more per week. Under the assumption that the employee does not bear the cost of the employer's share, the subsidy under H.R. 3600 is less than 100 percent for families below 100 percent of poverty because the subsidy schedule only provides a complete subsidy at an income level of $1,000 (indexed). Between $1,000 and 100 percent of poverty, the subsidy schedule calls for individuals to contribute (on a sliding scale basis) up to 3 percent of

their income. In Table 9, the net cost of insurance is higher than 3 percent -- 5.2 percent for families with incomes between 100 and 125 percent of poverty, and 6.2 percent for families with incomes between 125 and 150 percent of poverty -- because of the extra contributions required of self-employed persons or those working part time.

For families with incomes over 150 percent of poverty and less than $40,000, the family premium is capped at 3.9 percent of income. For families in the income range of 150-to-250 percent of poverty, the net cost of insurance is between 6 and 7 percent. Again, these rates are higher than 3.9 percent because of the partial payment of premiums by the self-employed in lieu of employer premiums.

The net cost to families is higher under the assumption that employees bear the cost of employer contributions. For those families with incomes below the poverty line the cost is 13 percent. The cost declines over the income scale to about 8 percent at 250 percent of poverty. Unlike the Cooper and Chafee proposals, the Health Security Act requires employer contributions. Although the Act does provide subsidies for workers in low wage firms, these subsidies are not well targeted to those individuals in families below the poverty level.

Table 10 shows the subsidies for families with a full time worker, but who do not have a plan where the employer contributes under current law. Under the assumption where the employee does not bear the employer's cost, the net premium cost (as a percentage of family income) is 2.9 percent for families in poverty. The cost ranges between 3.6 and 3.9 percent of income for families between 100 and 200 percent of poverty, and declines to 3.3 percent at 225-250 percent of poverty.

The net cost of insurance is 32 percent of family income for those in poverty under the assumption that the employee bears the employer's share of the premium. The cost is 22 percent for those with income between 100 and 125 percent of income and declines to about 13 percent at 225-250 percent of income. The high cost shows the significant burden that the Act places on low income workers resulting from the mandate for employer contributions. As already noted,

the employer cost is tempered by the employer subsidies, but their impact is dispersed because they are not directly related to the incomes of specific employees.

The results in Table 11 are roughly the same as those shown in Table 10. Table 11 shows the impact of H.R. 3600 for families who currently have a full-time worker and also have a health plan to which their employer contributes. The net cost of insurance (under the assumption that the employee does not bear the employer's cost) is equal to about 3 percent of income for families below the poverty line, and is between 3 and 4 percent of income in the range from 100 percent to 200 percent of poverty. The net cost of health insurance is 30 percent of family income for those with incomes under the poverty line under the assumption that the employee bears the employer's share of the premium. Again, the cost declines over the income scale, decreasing from 23 percent for those with income between 100 and 125 percent of income to 13 percent at 225-250 percent of income.

Summary

All three health reform proposals provide subsidies that would significantly reduce the cost of health insurance to low income individuals. The Administration's Health Security Act places a significantly heavier burden on those in poverty because of its employer mandate combined with its weakly targeted employer subsidies. Because neither the Cooper nor Chafee proposals require employer contributions, individuals below the poverty line receive 100 percent subsidies for the purchase of health insurance. For those individuals who receive an employer contribution, the net cost under the Cooper and Chafee proposals is likely to be higher than under the Health Security Act because these proposals do not provide explicit employer subsidies.

Table 3. Premium Subsidies Under H.R. 3222
(Persons With No Full Time Job)

Percent of Poverty	(1) Average Family Income	(2) Average Insurance Premium	(3) Average Employer Premium	(4) Average Employer Subsidy	(5) Average Family Premium	(6) Average Family Subsidy	Employee Does Not Bear Employer Premium 1/ (7) Average Family Net Premium (5) - (6)	Employee Does Not Bear Employer Premium 1/ (8) Net Premium as a percent of Family Income (7) / (1)	Employee Bears Employer Premium (9) Average Family Net Premium [(3)+(5)] - [(4)+(6)]	Employee Bears Employer Premium (10) Net Premium as a Percent of Family Income (9) / (1)
Under 100%	$3,179	$3,455	$0	$0	$3,455	$3,455	$0	0.0%	$0	0.0%
100 - 125%	$11,195	$3,534	$0	$0	$3,534	$3,113	$421	3.8%	$421	3.8%
125 - 150%	$14,148	$3,706	$0	$0	$3,706	$2,310	$1,396	9.9%	$1,396	9.9%
150 - 175%	$16,255	$3,593	$0	$0	$3,593	$1,337	$2,256	13.9%	$2,256	13.9%
175 - 200%	$19,405	$3,782	$0	$0	$3,782	$489	$3,292	17.0%	$3,292	17.0%
200 - 225%	$21,859	$3,882	$0	$0	$3,882	$0	$3,882	17.8%	$3,882	17.8%
225 - 250%	$24,605	$3,979	$0	$0	$3,979	$0	$3,979	16.2%	$3,979	16.2%
Over 250%	$55,149	$4,058	$0	$0	$4,058	$0	$4,058	7.4%	$4,058	7.4%
Total	$15,917	$3,624	$0	$0	$3,624	$2,383	$1,240	7.8%	$1,240	7.8%

1/ In this short-run analysis, the employer share of the premium has been excluded from the cost to families of health insurance. In the long-run, we would expect workers to bear a high percentage of the employer's cost, net of employer subsidies.

Table 4. Premium Subsidies Under H.R. 3222
(Persons With Full Time Job and No Employer Contribution)

Percent of Poverty	(1) Average Family Income	(2) Average Insurance Premium	(3) Average Employer Premium	(4) Average Employer Subsidy	(5) Average Family Premium	(6) Average Family Subsidy	Employee Does Not Bear Employer Premium 1/ (7) Average Family Net Premium (5) - (6)	Employee Does Not Bear Employer Premium 1/ (8) Net Premium as a percent of Family Income (7) / (1)	Employee Bears Employer Premium (9) Average Family Net Premium [(3)+(5)] - [(4)+(6)]	Employee Bears Employer Premium (10) Net Premium as a Percent of Family Income (9) / (1)
Under 100%	$8,546	$4,743	$0	$0	$4,743	$4,743	$0	0.0%	$0	0.0%
100 - 125%	$13,358	$4,540	$0	$0	$4,540	$3,975	$565	4.2%	$565	4.2%
125 - 150%	$15,002	$4,100	$0	$0	$4,100	$2,579	$1,522	10.1%	$1,522	10.1%
150 - 175%	$19,147	$4,494	$0	$0	$4,494	$1,674	$2,821	14.7%	$2,821	14.7%
175 - 200%	$21,711	$4,554	$0	$0	$4,554	$575	$3,979	18.3%	$3,979	18.3%
200 - 225%	$23,696	$4,332	$0	$0	$4,332	$0	$4,332	18.3%	$4,332	18.3%
225 - 250%	$28,380	$4,775	$0	$0	$4,775	$0	$4,775	16.8%	$4,775	16.8%
Over 250%	$57,325	$4,861	$0	$0	$4,861	$0	$4,861	8.5%	$4,861	8.5%
Total	$33,473	$4,650	$0	$0	$4,650	$1,405	$3,245	9.7%	$3,245	9.7%

1/ In this short-run analysis, the employer share of the premium has been excluded from the cost to families of health insurance. In the long-run, we would expect workers to bear a high percentage of the employer's cost, net of employer subsidies.

Table 5. Premium Subsidies Under H.R. 3222
(Persons With Full Time Job and Employer Contribution)

Percent of Poverty	(1) Average Family Income	(2) Average Insurance Premium	(3) Average Employer Premium	(4) Average Employer Subsidy	(5) Average Family Premium	(6) Average Family Subsidy	Employee Does Not Bear Employer Premium 1/ (7) Average Family Net Premium (5) - (6)	Employee Does Not Bear Employer Premium 1/ (8) Net Premium as a percent of Family Income (7) / (1)	Employee Bears Employer Premium (9) Average Family Net Premium [(3)+(5)] - [(4)+(6)]	Employee Bears Employer Premium (10) Net Premium as a Percent of Family Income (9) / (1)
Under 100%	$8,846	$4,589	$3,244	$0	$1,345	$1,345	$0	0.0%	$3,244	36.7%
100 - 125%	$14,438	$4,814	$3,639	$0	$1,176	$581	$594	4.1%	$4,233	29.3%
125 - 150%	$16,809	$4,503	$3,413	$0	$1,090	$70	$1,020	6.1%	$4,433	26.4%
150 - 175%	$20,097	$4,618	$3,598	$0	$1,020	$5	$1,015	5.1%	$4,613	23.0%
175 - 200%	$23,151	$4,683	$3,656	$0	$1,027	$0	$1,027	4.4%	$4,683	20.2%
200 - 225%	$25,626	$4,556	$3,571	$0	$985	$0	$985	3.8%	$4,556	17.8%
225 - 250%	$29,078	$4,702	$3,705	$0	$998	$0	$998	3.4%	$4,702	16.2%
Over 250%	$65,695	$5,037	$3,993	$0	$1,044	$0	$1,044	1.6%	$5,037	7.7%
Total	$56,169	$4,949	$3,901	$0	$1,047	$40	$1,008	1.8%	$4,909	8.7%

1/ In this short-run analysis, the employer share of the premium has been excluded from the cost to families of health insurance. In the long-run, we would expect workers to bear a high percentage of the employer's cost, net of employer subsidies.

Table 6. Premium Subsidies Under H.R. 3704
(Persons With No Full Time Job)

Percent of Poverty	(1) Average Family Income	(2) Average Insurance Premium	(3) Average Employer Premium	(4) Average Employer Subsidy	(5) Average Family Premium	(6) Average Family Subsidy	Employee Does Not Bear Employer Premium 1/ (7) Average Family Net Premium (5) - (6)	Employee Does Not Bear Employer Premium 1/ (8) Net Premium as a percent of Family Income (7) / (1)	Employee Bears Employer Premium (9) Average Family Net Premium [(3)+(5)] - [(4)+(6)]	Employee Bears Employer Premium (10) Net Premium as a Percent of Family Income (9) / (1)
Under 100%	$3,179	$3,455	$0	$0	$3,455	$3,455	$0	0.0%	$0	0.0%
100 - 125%	$11,195	$3,534	$0	$0	$3,534	$3,257	$276	2.5%	$276	2.5%
125 - 150%	$14,148	$3,706	$0	$0	$3,706	$2,781	$925	6.5%	$925	6.5%
150 - 175%	$16,255	$3,593	$0	$0	$3,593	$2,069	$1,524	9.4%	$1,524	9.4%
175 - 200%	$19,405	$3,782	$0	$0	$3,782	$1,470	$2,311	11.9%	$2,311	11.9%
200 - 225%	$21,859	$3,882	$0	$0	$3,882	$821	$3,061	14.0%	$3,061	14.0%
225 - 250%	$24,605	$3,979	$0	$0	$3,979	$174	$3,805	15.5%	$3,805	15.5%
Over 250%	$55,149	$4,058	$0	$0	$4,058	$38	$4,020	7.3%	$4,020	7.3%
Total	$15,917	$3,624	$0	$0	$3,624	$2,515	$1,109	7.0%	$1,109	7.0%

1/ In this short-run analysis, the employer share of the premium has been excluded from the cost to families of health insurance. In the long-run, we would expect workers to bear a high percentage of the employer's cost, net of employer subsidies.

Table 7. Premium Subsidies Under H.R. 3704
(Persons With Full Time Job and No Employer Contribution)

Percent of Poverty	(1) Average Family Income	(2) Average Insurance Premium	(3) Average Employer Premium	(4) Average Employer Subsidy	(5) Average Family Premium	(6) Average Family Subsidy	Employee Does Not Bear Employer Premium 1/ (7) Average Family Net Premium (5) - (6)	Employee Does Not Bear Employer Premium 1/ (8) Net Premium as a percent of Family Income (7) / (1)	Employee Bears Employer Premium (9) Average Family Net Premium [(3)+(5)] - [(4)+(6)]	Employee Bears Employer Premium (10) Net Premium as a Percent of Family Income (9) / (1)
Under 100%	$8,546	$4,743	$0	$0	$4,743	$4,743	$0	0.0%	$0	0.0%
100 - 125%	$13,358	$4,540	$0	$0	$4,540	$4,169	$371	2.8%	$371	2.8%
125 - 150%	$15,002	$4,100	$0	$0	$4,100	$3,087	$1,014	6.8%	$1,014	6.8%
150 - 175%	$19,147	$4,494	$0	$0	$4,494	$2,565	$1,930	10.1%	$1,930	10.1%
175 - 200%	$21,711	$4,554	$0	$0	$4,554	$1,788	$2,766	12.7%	$2,766	12.7%
200 - 225%	$23,696	$4,332	$0	$0	$4,332	$950	$3,382	14.3%	$3,382	14.3%
225 - 250%	$28,380	$4,775	$0	$0	$4,775	$202	$4,573	16.1%	$4,573	16.1%
Over 250%	$57,325	$4,861	$0	$0	$4,861	$43	$4,817	8.4%	$4,817	8.4%
Total	$33,473	$4,650	$0	$0	$4,650	$1,719	$2,931	8.8%	$2,931	8.8%

1/ In this short-run analysis, the employer share of the premium has been excluded from the cost to families of health insurance. In the long-run, we would expect workers to bear a high percentage of the employer's cost, net of employer subsidies.

Table 8. Premium Subsidies Under H.R. 3704
(Persons With Full Time Job and Employer Contribution)

Percent of Poverty	(1) Average Family Income	(2) Average Insurance Premium	(3) Average Employer Premium	(4) Average Employer Subsidy	(5) Average Family Premium	(6) Average Family Subsidy	Employee Does Not Bear Employer Premium 1/ (7) Average Family Net Premium (5) - (6)	Employee Does Not Bear Employer Premium 1/ (8) Net Premium as a percent of Family Income (7) / (1)	Employee Bears Employer Premium (9) Average Family Net Premium [(3)+(5)] - [(4)+(6)]	Employee Bears Employer Premium (10) Net Premium as a Percent of Family Income (9) / (1)
Under 100%	$8,846	$4,589	$3,244	$0	$1,345	$1,345	$0	0.0%	$3,244	36.7%
100 - 125%	$14,438	$4,814	$3,639	$0	$1,176	$1,176	$0	0.0%	$3,639	25.2%
125 - 150%	$16,809	$4,503	$3,413	$0	$1,090	$1,089	$1	0.0%	$3,414	20.3%
150 - 175%	$20,097	$4,618	$3,598	$0	$1,020	$1,014	$5	0.0%	$3,603	17.9%
175 - 200%	$23,151	$4,683	$3,656	$0	$1,027	$989	$37	0.2%	$3,694	16.0%
200 - 225%	$25,626	$4,556	$3,571	$0	$985	$826	$159	0.6%	$3,731	14.6%
225 - 250%	$29,078	$4,702	$3,705	$0	$998	$174	$823	2.8%	$4,528	15.6%
Over 250%	$65,695	$5,037	$3,993	$0	$1,044	$3	$1,041	1.6%	$5,034	7.7%
Total	$56,169	$4,949	$3,901	$0	$1,047	$187	$860	1.5%	$4,762	8.5%

1/ In this short-run analysis, the employer share of the premium has been excluded from the cost to families of health insurance. In the long-run, we would expect workers to bear a high percentage of the employer's cost, net of employer subsidies.

Table 9. Premium Subsidies Under H.R. 3600
(Persons With No Full Time Job)

Percent of Poverty	(1) Average Family Income	(2) Average Insurance Premium	(3) Average Employer Premium	(4) Average Employer Subsidy	(5) Average Family Premium	(6) Average Family Subsidy	Employee Does Not Bear Employer Premium 1/ (7) Average Family Net Premium (5) - (6)	Employee Does Not Bear Employer Premium 1/ (8) Net Premium as a percent of Family Income (7) / (1)	Employee Bears Employer Premium (9) Average Family Net Premium [(3)+(5)] - [(4)+(6)]	Employee Bears Employer Premium (10) Net Premium as a Percent of Family Income (9) / (1)
Under 100%	$3,179	$3,455	$457	$202	$2,954	$2,837	$117	3.7%	$417	13.1%
100 - 125%	$11,195	$3,534	$904	$366	$2,559	$1,977	$581	5.2%	$1,190	10.6%
125 - 150%	$14,148	$3,706	$943	$324	$2,648	$1,767	$882	6.2%	$1,615	11.4%
150 - 175%	$16,255	$3,593	$818	$327	$2,683	$1,670	$1,012	6.2%	$1,596	9.8%
175 - 200%	$19,405	$3,782	$605	$185	$3,100	$1,797	$1,303	6.7%	$1,800	9.3%
200 - 225%	$21,859	$3,882	$676	$222	$3,113	$1,675	$1,439	6.6%	$1,986	9.1%
225 - 250%	$24,605	$3,979	$672	$249	$3,199	$1,671	$1,528	6.2%	$2,059	8.4%
Over 250%	$55,149	$4,058	$468	$144	$3,469	$1,371	$2,098	3.8%	$2,543	4.6%
Total	$15,917	$3,624	$547	$215	$3,007	$2,311	$696	4.4%	$1,097	6.9%

1/ In this short-run analysis, the employer share of the premium has been excluded from the cost to families of health insurance. In the long-run, we would expect workers to bear a high percentage of the employer's cost, net of employer subsidies.

Table 10. Premium Subsidies Under H.R. 3600
(Persons With Full Time Job and No Employer Contribution)

Percent of Poverty	(1) Average Family Income	(2) Average Insurance Premium	(3) Average Employer Premium	(4) Average Employer Subsidy	(5) Average Family Premium	(6) Average Family Subsidy	Employee Does Not Bear Employer Premium 1/ (7) Average Family Net Premium (5) - (6)	Employee Does Not Bear Employer Premium 1/ (8) Net Premium as a percent of Family Income (7) / (1)	Employee Bears Employer Premium (9) Average Family Net Premium [(3)+(5)] - [(4)+(6)]	Employee Bears Employer Premium (10) Net Premium as a Percent of Family Income (9) / (1)
Under 100%	$8,546	$4,743	$3,318	$1,306	$949	$704	$245	2.9%	$2,733	32.0%
100 - 125%	$13,358	$4,540	$3,312	$1,235	$908	$430	$478	3.6%	$2,874	21.5%
125 - 150%	$15,002	$4,100	$3,130	$1,137	$820	$239	$581	3.9%	$2,724	18.2%
150 - 175%	$19,147	$4,494	$3,458	$1,169	$899	$164	$735	3.8%	$3,161	16.5%
175 - 200%	$21,711	$4,554	$3,515	$1,162	$911	$118	$793	3.7%	$3,274	15.1%
200 - 225%	$23,696	$4,332	$3,436	$1,100	$866	$55	$811	3.4%	$3,176	13.4%
225 - 250%	$28,380	$4,775	$3,799	$1,212	$955	$29	$926	3.3%	$3,534	12.5%
Over 250%	$57,325	$4,861	$3,985	$1,051	$972	$1	$971	1.7%	$3,809	6.6%
Total	$33,473	$4,650	$3,631	$1,138	$930	$181	$749	2.2%	$3,331	10.0%

1/ In this short-run analysis, the employer share of the premium has been excluded from the cost to families of health insurance. In the long-run, we would expect workers to bear a high percentage of the employer's cost, net of employer subsidies.

Table 11. Premium Subsidies Under H.R. 3600
(Persons With Full Time Job and Employer Contribution)

Percent of Poverty	(1) Average Family Income	(2) Average Insurance Premium	(3) Average Employer Premium	(4) Average Employer Subsidy	(5) Average Family Premium	(6) Average Family Subsidy	Employee Does Not Bear Employer Premium 1/ (7) Average Family Net Premium (5) - (6)	Employee Does Not Bear Employer Premium 1/ (8) Net Premium as a percent of Family Income (7) / (1)	Employee Bears Employer Premium (9) Average Family Net Premium [(3)+(5)] - [(4)+(6)]	Employee Bears Employer Premium (10) Net Premium as a Percent of Family Income (9) / (1)
Under 100%	$8,846	$4,589	$2,843	$857	$1,328	$1,058	$271	3.1%	$2,674	30.2%
100 - 125%	$14,438	$4,814	$3,302	$885	$1,140	$601	$539	3.7%	$3,329	23.1%
125 - 150%	$16,809	$4,503	$3,138	$905	$1,053	$384	$669	4.0%	$3,214	19.1%
150 - 175%	$20,097	$4,618	$3,382	$890	$987	$210	$777	3.9%	$3,518	17.5%
175 - 200%	$23,151	$4,683	$3,528	$926	$999	$136	$862	3.7%	$3,621	15.6%
200 - 225%	$25,626	$4,556	$3,513	$839	$947	$69	$878	3.4%	$3,649	14.2%
225 - 250%	$29,078	$4,702	$3,666	$855	$976	$46	$931	3.2%	$3,802	13.1%
Over 250%	$65,695	$5,037	$4,406	$839	$1,025	$8	$1,017	1.5%	$4,189	6.4%
Total	$56,169	$4,949	$4,188	$847	$1,026	$65	$962	1.7%	$4,037	7.2%

1/ In this short-run analysis, the employer share of the premium has been excluded from the cost to families of health insurance. In the long-run, we would expect workers to bear a high percentage of the employer's cost, net of employer subsidies.

Technical Note

Our analysis compares each health reform proposal using a common set of assumptions. These assumptions include the same basic premium structure and policy coverage. The premium structure consists of four different types of policies, those for: single individuals; childless couples; single-parent families; and two-parent couples. The premium rates (for 1998) are estimated based on the methodology specified in H.R. 3600 under the assumption that the premium caps are 50 percent effective. The premium rates are shown below.

Table 12
Estimated Premiums (1998)

Policy Unit Type	Household Premium	Employer Share
Singles	$2,702	$2,161
Couples	$5,403	$2,963
Single Parent	$5,268	$3,865
Married Parent	$7,159	$3,865

We base our results on 1998 premium rates, but assume that each bill has been fully phased-in. Specifically, we assume that the premium subsidy schedule under HR 3704 (the Chafee bill) has been fully phased-in, even though the bill does not call for a full phase-in of the premium subsidy schedule until 2005. For all three bills, we have also assumed that there are sufficient Federal dollars to finance 100 percent of the subsidies specified in each of the bills. We have made these stylized assumptions in order to compare the structure of insurance premium subsidies in each bill without regard to the large differences in the features of the bills that may significantly impact the gross cost of health insurance in 1998.

For this analysis, we have excluded individuals who are covered by Medicare because Medicare is generally left unchanged by all three health reform bills. We have also excluded Medicaid recipients who receive cash benefits (AFDC or SSI). Under the Administration's proposal, these individuals would be covered by health alliances, and would bear no premium cost. The Federal government would pay 95 percent of the per capita Medicaid spending, excluding Disproportionate Share Hospital (DSH) payments, to the alliances to cover these individuals. Under the Chafee bill, all Medicaid recipients would still be covered by Medicaid, although states would have the option of enrolling these individuals in a qualified health plan. The Cooper Bill eliminates Medicaid and folds all recipients into the same health insurance system used to cover non-Medicaid recipients. Those recipients whose incomes exceed the poverty line would not receive a 100 percent premium subsidy and would be required to pay part of their health insurance premiums. In general, Medicaid cash recipients would continue to receive health care without paying an insurance premium under all three health reform proposals, with the exception of those individuals over the poverty line under the Cooper bill.

Our analysis uses as its core database the March 1993 Current Population Survey (CPS). This database has been aged to 1998 to be consistent with population projections by the Census Bureau and economic projections of the Congressional Budget Office. For this analysis, individuals are grouped according to health "insurance policy units." An insurance policy unit is somewhat different than the definition of a family that is normally used by the Bureau of the Census in creating the CPS. A family for the purpose of the CPS includes two persons or more residing together and who are related by birth, marriage or adoption. Thus, a family may include individuals that would not normally be covered by the insurance policy of the family head (or spouse), such as parents, children over 18 (or over 24 in college), or grandchildren. For the purposes of defining a policy unit, we split CPS families with "ineligible" individuals into multiple policy units. For example, single children over 18 (or over 24 in college) or married children are distinguished as a separate policy unit. Parents (single or married) are also distinguished as a separate policy unit. The income level and the poverty standard against which a policy unit is compared is adjusted to reflect the size and composition of that policy unit. The insurance policy unit definition used here follows H.R. 3600 in specifying four different types

of units: singles, married couples, single parents and married parents. In the discussion that follows, the terms "policy unit" and "family" are used interchangeably and both relate to the policy unit concept.

H.R. 3600 contains a provision that would cap a firm's premium costs based upon its number of employees and its average annual wages. Therefore, it is necessary to have accurate employment and payroll information on a company-level basis. KPMG Peat Marwick has developed a business health database that is used to produce estimates of the impact of health policies on virtually all private businesses in the country. Large firms in the database are based on financial records from the *Disclosure* database.[6] The *Disclosure* database contains financial reports (filed with the SEC) for over 10,000 of the nation's largest companies. Small companies are represented in the business database by a sample of "synthetic" firms whose payroll and employment are based on *County Business Patterns* data.[7] The large and small firm samples are combined to form the core business database.

The calculation of the impact of the H.R. 3600 on federal subsidies and employers premium payments is based upon several factors, including: the applicable premium cap based upon full-time equivalent employment and average annual wages and the mix of policy units for each firm. The CPS household information on FTE employment and the mix of policy units by two-digit SIC code and by six employment size classes is used as control total for the business database. This information is used to: (1) convert full- and part-time employment to FTE employment based upon two-digit SIC codes and employment classes; and (2) determine each company's mix of employees. These data provide the basis for calculating each company's premium payments as well as the applicable premium cap based upon FTE employment and average annual wages.

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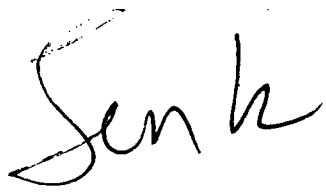
[6] *Disclosure SEC Database*, Disclosure Information Services, 1993.

[7] U.S. Bureau of the Census, *County Business Patterns*, 1990.

The estimates of the federal subsidy and each employer's premium payments is based on each employer's policy unit mix, FTE employment and their average annual wages. The employer premium payments are determined by multiplying the number of employees times the premium amount for each policy unit type. The federal subsidy is estimated based upon each company's FTE employment and their average annual wages.

The employer subsidy that is credited on behalf of an individual in the CPS database is the average subsidy credited to all firms in a specific industry and employment size class. For example, all workers in the retail trade industry employed by firms with employment under 25 are assigned the same average employer subsidy. To some extent, this averaging assumption may understate the subsidies for low-wage workers and overstate the subsidies for high wage workers. Within any industry/employment size category, to the degree that low wage workers tend to be grouped in specific firms, and vice versa, the average employer subsidy will understate the employer subsidies of low wage workers and overstate the subsidies of high wage workers.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FAMILIES AND NATIONAL HEALTH REFORM

A COMPARISON OF FAMILY PREMIUM PAYMENT RESPONSIBILITIES UNDER CURRENT LEGISLATIVE PROPOSALS

by

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Prepared for the Kaiser Commission on the Future of Medicaid

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EXECUTIVE SUMMARY

No aspect of the current health reform debate is more fundamental than assuring that families' health insurance premiums will be affordable. This study reviews the issue of affordable premiums for a family of three under the President's plan, the Cooper/Breaux bill, the Chafee/Thomas bill and the Wellstone/McDermott bill from two perspectives. First, it calculates the amount of **assured** premium support provided to families under each measure. Second, in light of the important connection between health reform and welfare reform, it measures the extent to which each measure's premium assistance provisions act to either encourage or discourage work.

Overview of Major Findings

Premium affordability

Only the President's bill and the McDermott/Wellstone bill assure low and moderate income families that their premiums will be affordable. In contrast, the Thomas/Chafee and Cooper/Breaux proposals make coverage more affordable for families at or below the poverty level. As these families make gains in income, however, their insurance becomes less affordable.

- Under the President's plan no family working full-time and with earnings under $40,000 would pay more than 3.9 percent of income for an average plan. A family earning approximately $18,000 would pay only $696. A family earning about $29,000 would pay $780. Under the McDermott/Wellstone plan, a family earning about $18,000 would pay $112, while a family earning $29,000 would pay $362.

- Under the Thomas/Chafee bill a family earning $18,000 could be left with premium payments as high as $1,400 (7.8 percent of income). A family earning about $29,000 could pay as much as $3,900 (13.1 percent of income).

- Under the Cooper/Breaux bill a family earning $18,000 could be left with premiums as high as $1,950 (10.9 percent of income). A family earning $29,000 could pay $3,900 (13.1 percent of income). A family earning slightly less than $24,000 could pay $3,900 (16.4 percent of income).

Impact on Work

Because the President's plan and the McDermott/Wellstone bill provide assured premium financial support for both low and middle income persons, both bills encourage families to make the welfare-to-work transition. Health coverage is assured regardless of whether a family receives welfare or not, and coverage is assured to be affordable. On the other hand, the Cooper/Breaux and Thomas/Chafee plans create powerful work disincentives.

- A worker earning a poverty-level wage who increases her earnings by 50 percent could lose over 23 percent of her wage increase to higher premiums under the Thomas/Chafee plan.

- Under the Cooper/Breaux plan, the wage earner could lose one-third of her increased earnings to higher premiums.

- When the loss of premium support is combined with the phase-out of the Earned Income Tax Credit, a low-income wage-earner could lose almost 43 percent of her wage increase to lost tax credits and higher premiums under the Thomas/Chafee plan.

- In the case of the Cooper/Breaux plan, the worker could lose more than half of her additional earnings to the loss of the credit and higher insurance premium payments.

INTRODUCTION

No aspect of the current health reform debate is more fundamental than assuring that families' health insurance premiums will be affordable. In recent weeks and months a great deal of attention has been focused on the payment responsibilities that business and government will face under a reformed health care system. Yet surprisingly little attention has been paid to the issue of whether families themselves will be assured of affordable health insurance costs.

This study, prepared for the Kaiser Commission on the Future of Medicaid, analyzes the degree to which major health reform proposals now before Congress address the issue of premium affordability for families. In this paper we focus particularly on working families with low and moderate incomes.

We review the issue of premium affordability in two different ways. First, we identify the amount of assured premium support provided to families under each measure. Second, in light of the important connection between health reform and welfare reform drawn by both the President and many Members of Congress, we estimate the extent to which each measure's premium assistance provisions act to either encourage or discourage work.

The question of premium affordability is particularly important, because of the high cost of health care. Health insurance is extremely expensive. Group health plans, including those with relatively modest levels of coverage and high patient cost sharing, involve family expenditures of several thousand dollars annually. Moreover, even comprehensive health insurance plans with low out-of-pocket payments for covered services frequently cover only a portion of family health costs, especially in the case of families that include one or more members with higher than average medical and related health care needs.

Out-of-pocket health expenditures account for more than 22 percent of all personal health spending.[1] The current high level of spending on out-of-pocket costs reflects the health needs that insurance simply does not reach, such as services and benefits that are completely uncovered, and items and services that are only partially covered and that remain subject to deductibles and copayments. Moreover, it is likely that any health insurance proposal that ultimately emerges will continue to cover less than all services on a "first dollar" and 100-percent-of-charge basis. For this reason, the amount of premium costs that families must bear directly is a crucial "first order" issue for policy-makers.

The issue of health care affordability is a complex one. Accurately calculated, health costs include not only premium payments but other forms of

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[1] Suzanne W. Letsch, et al. "National Health Expenditures, 1991." Health Care Financing Review, Winter, 1992, pp. 1-30.

health spending as well, such as deductibles, coinsurance, and uncovered medical and health-related expenses. Experts have estimated that total out-of-pocket health spending should not exceed 10 percent of families' wages;[2] moreover, the Internal Revenue Code treats health expenses that exceed seven percent of adjusted gross income as catastrophic and therefore deductible costs. Whatever the proper figure, it is clear that even under the most comprehensive health care financing schemes, family health spending extends well beyond insurance premiums themselves and therefore that families' direct premium burdens must be kept low.

The high cost of health insurance means that only the wealthiest families can afford coverage without significant financial assistance from a third party. The Congressional Budget Office has estimated that in 1994 the average private health insurance group coverage premium for a one-parent family will cost $4,095. Without assured premium financial assistance in the form of either employer contributions, government contributions, or both, even the cost of basic coverage is beyond the reach of moderate and middle income working families (those with earnings under $40,000). It is these families who are most at risk of being uninsured.[3]

This study consists of two parts. The first part reviews four health reform proposals and calculates for each plan the amount of **assured premium support** each bill provides to low, moderate, and middle income working families. The second part of the study measures the effect of increased earnings on the level of assured premium support for low income workers. We estimate the impact of increased earnings on the level of assured premium support under each plan, both alone and in combination with the phase-out of the Earned Income Tax Credit (EITC) as wages increase.

STUDY METHODOLOGY

In this study we measure the amount of each bill's assured premium support level by comparing each measure's statutory premium support formula against the cost of an average premium for a full-time working family consisting of a single adult with two dependent children. The study assumes that virtually all income for our hypothetical families is derived from earnings. The health insurance premium used is the premium for a single parent household with children, as calculated by

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[2] For a discussion of income-related cost-sharing, see Thomas Rice and Kenneth E. Thorpe, "Income-Related Cost Sharing in Health Insurance," Health Affairs, Spring 1993, pp. 22-39.

[3]Employee Benefit Research Institute, Sources of Health Insurance and Characteristics of the Uninsured, Analysis of the March, Current Population Survey (January 1994) p. 30.

the Congressional Budget Office, and deflated to 1993 dollars.[4] We selected 1993 as the study year and used 1993 federal poverty guidelines issued by the Commerce Department. The EITC formula used in Part 2 is the methodology that will take effect in 1996, deflated to 1993 dollars.

The Appendix to this study contains a description of the various statutory premium assistance subsidy formulas contained in each bill and the assumptions that we made in performing the calculations. Below is a brief overview of each plan's family premium assistance provisions.

LEGISLATION REVIEWED AND DESCRIPTION OF PREMIUM ASSISTANCE PROVISIONS

The legislation reviewed in this study include four of the six major national health reform proposals introduced as of December 22, 1993.[5] They are:

- The Health Security Act (H.R. 3600/S. 1757), developed by the President's Health Reform Task Force and introduced by Representative Richard Gephardt and Senator George Mitchell;
- The Health Equity and Access Reform Today Act (H.R. 3704/S. 1770), introduced by Representative Bill Thomas and Senator John Chafee.
- The Managed Competition Act (H.R. 3222/S. 1579) introduced by Representative Jim Cooper and Senator John Breaux; and,
- The American Health Security Act (H.R. 1200/S. 491), introduced by Representative Jim McDermott and Senator Paul Wellstone;

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[4]Since no measures except the President's bill and the McDermott/Wellstone bill contain a defined benefit package, the premium chosen may overstate or understate the cost of a health plan. For example, if coverage were less generous than the President's bill, the premium would be lower. However, out-of-pocket payments might rise significantly for many families, leaving them in a situation which is worse overall.

[5]Two measures were not included in this study. Both the Affordable Health Care Now Act (introduced by Representative Robert Michel and Senator Trent Lott and The Consumer Choice Health Security Act (introduced by Senator Nickles and Representative Stearns) were excluded. The Stearns/Nickles bill was excluded because, unlike the other measures, it does not rely on a mix of employer, government and individual financing. Instead, employer contributions are prohibited; the bill provides credits for the sum of health insurance premiums and uncovered medical expenses that exceed 10 percent of an individual's adjusted gross income, with credits increasing in size as the percentage of family income spent on health care grows. The Michel/Lott bill was excluded because the subsidy program is carried out through an optional state Medicaid expansion and it is not possible to measure which states will respond to the option or to what degree.

President Clinton's plan: The Health Security Act would achieve universal coverage by 1998 for all U.S. citizens and legal residents not eligible for Medicare through a system of subsidized private group health coverage. Private insurance costs for individuals and families would be borne by a combination of employer, individual, and government contributions. In the case of full-time workers, employers would contribute 80 percent of the average cost of a group health plan premium, and workers would be responsible for the remainder (known as the "family share"). Additional financial assistance would be available for lower and moderate income working families with incomes under $40,000 to further reduce the cost of the family's share of the premium.

Under the President's plan, a full-time wage earner who does not receive either AFDC or SSI benefits would receive a premium contribution from his or her employer toward the cost of coverage equal to 80 percent of the weighted average premium for the regional alliance through which the individual is enrolled. The individual or family is responsible for paying the remaining cost of the plan chosen, which would be 20 percent of the premium if an average cost plan is selected .

In addition to the guaranteed employer contribution, the President's bill provides for a contribution toward the family share in the case of low and moderate income families. This contribution is not available, however, to individuals employed by large employers (with 5,000 or more employees) which chose to form corporate alliances. The contribution toward the family share is designed to ensure that full-time working families with incomes below $40,000 pay no more than 3.9 percent of family income for their premiums and that working families with adjusted gross incomes above $1,000 but below 150 percent of poverty pay a somewhat lesser amount.

The Thomas/Chafee plan: The Thomas/Chafee bill provides a federally-administered voucher program for individuals and families who have incomes under 240 percent of the federal poverty level. The voucher program, which would apply toward the cost of private insurance, would be fully phased-in by the year 2005. The implementation of the program, however, is completely subject to savings realized in Medicare and Medicaid and tax revenue increases. Depending on family income, each family eligible for voucher assistance would receive a voucher worth a certain value. This value of the voucher would be a percentage of the lesser of either the actual annual premium paid by the family or the "voucher percentage." The "voucher percentage" equals the average premium cost of the lowest priced one-half of all standard benefit plans offered.

Under the statutory formula the vouchers range in value from 100 percent of the upper voucher limit for families with adjusted gross incomes under the federal poverty level to seven percent of the upper limit for families with incomes at 230 percent of poverty. For example, a family of three with an adjusted gross

income of $17,835 (150 percent of the federal poverty level) would receive a voucher worth 50 percent of the lesser of the actual cost of the health plan it selected or the average cost of the lower half of all health plans offered in the family's "health care coverage area." A family of three with an adjusted gross income of $27,347 (230 percent of poverty) would receive a voucher worth seven percent of the lesser of the value of the plan chosen or the average lower cost plan.

The Cooper/Breaux plan: The Managed Competition Act seeks to make private health insurance coverage more widely available to working-age Americans and their families through a series of reforms designed to reduce the cost of group health insurance. The bill also contains certain regulatory and subsidy provisions (including mandatory price discounting by health plans and direct financial subsidies for certain low and moderate income families) designed to reduce the cost of private coverage.

The Cooper/Breaux plan's financial assistance methodology is unique. Unlike the other bills considered here, the plan relies heavily on both direct assistance to families and a system of mandatory discounts by health plans. Even those health plans whose premiums represent the lowest recognized price in health plan purchasing cooperatives would be required to further discount their prices below this level for low-income families. All families with members employed in small firms and with "family adjusted income" (earnings plus exempt interest payment plus Social Security benefits) below 200 percent of the "applicable poverty level" (a state-based poverty measure that replaces the federal poverty measure) would be eligible for these mandatory discounts. In some states, this "family adjusted income" level might be higher than the federal poverty level; in other states, adjusted poverty may be below the federal poverty level.

It is important to note that the mandatory discounts are available only to individuals who obtain coverage under an accountable health plan through a health plan purchasing cooperative. Therefore, the discounts do not apply to employees of large employers (with more than 100 employees).

The bill does not provide a statutory floor on the discounted federal payment for poor families or on the discounts that the plans are required to provide. Instead, the discounts are to be calculated in relation to the amount of funding available to provide low-income assistance in any year. The amount of public funding available to provide such assistance is capped and varies in accordance with total budget savings. Thus, in any given year, the subsidy could be well below even the lowest-priced plan in many cooperatives, and health plans' mandatory discounts would deepen as well.

While the bill provides for a reconciliation process to assure the "equitable

distribution" among all health plans of these mandatory reductions in premiums, the legislative language is ambiguous about what amount is "equitable" and how much of the low income premium discount each health plan would bear.[6] Moreover, none of the funds transferred through reconciliation would be returned to families in the form of lower insurance premiums.

Thus, much of the guaranteed assistance under the Cooper/Breaux plan comes, not from governmental or employer-provided assistance, but through reliance on sizable cost-shifting among health plans themselves, although the magnitude of the cost shift is unclear.

The subsidy received by each family with "family adjusted income" under the "applicable " poverty level ranges from 100 percent of the discounted price to zero percent of the discounted price. The subsidy phases out at a level significantly lower than that used under the Thomas/Chafee bill.

The McDermott/Wellstone plan: The American Health Security Act would extend government-administered health insurance coverage to all U.S. citizens and legal residents. In the case of working age Americans, the cost of coverage would be borne through an 8.4 percent payroll tax on large employers, a 4.0 percent payroll tax on small employers, and a 2.1 percent tax on individuals' taxable incomes. A variety of "sin" taxes also would be imposed.

FINDINGS

Findings for the three premium-based measures (Clinton, Thomas/Chafee and Cooper/Breaux) appear on Tables 1 - 3. Because the McDermott/Wellstone bill does not rely on premium financing or the purchase of private health insurance, we present separately on Tables 4A - 4C our findings regarding the bill's effect on the family's out-of-pocket expenses and how the family's tax liability and earned income tax credit is affected by increased earnings. Figures 1-4 compare all four bills.

Part 1: Assured Premium Assistance Levels

Table 1 shows the size of a family's premium responsibility at various income levels under the Clinton, Cooper/Breaux and Thomas/Chafee plans. The Clinton plan provides the greatest level of assured premium support for low and

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[6]Health plans with high numbers of low income enrollees would receive some relief from this discounting system through a subsequent inter-plan "reconciliation" process. However, none of the funds transferred through reconciliation would be returned to families in the form of lower insurance premiums.

moderate income families. This is because under the Clinton plan no family working full-time and with adjusted gross income under $40,000 would face a premium burden greater than 3.9 percent of family income. It is notable, however, that under the President's plan, even full-time working families with poverty level incomes would be required to contribute to the cost of coverage.

The Cooper/Breaux and Thomas/Chafee plans are more generous to the poorest families. However, as shown in Figures 1 and 2, both bills place far greater burdens on near poor and moderate level income families. Moreover, at every income level up to 240 percent of poverty, the Cooper/Breaux plan places the greatest burden on families, since the it uses a steeper subsidy/discount phase-out schedule than the Thomas/Chafee plan which has a phase-out at 200 percent of poverty rather than 240 percent.

The potential premium payment exposure faced by low and moderate income wage earners and their families under the Cooper/Breaux plan is the most significant of the three measures. A family earning about $18,000 (150 percent of poverty) would face insurance premiums of $1,950 -- nearly 11 percent of the family's income. A family earning slightly more than $21,402 (180 percent of poverty) would face premium payments of nearly $3,120 (14.6 percent of income). A family earning $24,000 (200 percent of poverty) would potentially pay the entire premium of $3900 -- over 16 percent of family income.

The Thomas/Chafee plan premium burden is great, as well. Families at 180 percent, 200 percent and 250 percent of poverty would face premium burdens of 10.4 percent, 11.7 percent and 13.1 percent of family income, respectively. This level of payment responsibility is so large that it is highly unlikely that lower income families could comply with the Thomas/Chafee mandate to buy health insurance. Indeed, universal coverage (whether mandatory or voluntary) would be virtually impossible to achieve without a system for compensating for what otherwise would be billions of dollars in unpaid premiums by low and moderate income families.

Table 1 also shows that the impact of the lack of assured premium support under the Thomas/Chafee and Cooper/Breaux plans is not felt at only low-income levels. At $36,000 (300 percent of poverty) a family of three would use only two percent of its family income to buy an average-priced health insurance premium under the President's plan, since the remainder would come from the employer. Under both the Cooper/Breaux and Thomas/Chafee bills, however, the same family would have to devote potentially nearly 11 percent of income to health insurance premiums alone -- a more than five-fold difference in payment responsibility and a major burden on middle income families.

The accompanying Box illustrates the effects of each measure on a working family with moderate earnings and typical household costs.

This case study is based on a single parent working family with two dependent children. The mother currently has no health insurance and pays all of her family's medical expenses out-of-pocket. The following information shows the family's typical household expenses and the effects of each health care reform measure on her budget. Her annual adjusted gross income is $17,100, leaving her with a net income of $13,624 after taxes.

	Dollars	% OF NET INCOME
ANNUAL NET INCOME	$13,624.	100.%
ANNUAL EXPENSES		
Rent	$7,200	52.8%
Utilities	$3,600	26.4%
Food	$3,000	22.0%
Clothing	$1,200	8.8%
Educational Expenses	$2,400	17.6%
Other Expenses	$1,380	10.1%
Current Medical Expenses	$500	3.7%
EFFECTS OF HEALTH REFORM MEASURES		
Tax liability under the McDermott/Wellstone plan (HR 1200; S 491)	$87	0.6%
Premium Expenses under the President's plan (HR 3600; S 1757)	$667	4.9%
Premium Expenses under the Thomas/Chafee plan (HR 3704; S 1770)	$1,221	9.0%
Premium Expenses under the Cooper/Breaux plan (HR 3222; S 1579)	$1,709	12.5%

It is important to note that our assessment of the Thomas/Chafee and Cooper/Breaux bills may overstate the level of assistance each furnishes to families. The Thomas/Chafee plan subsidy is conditioned on achieving savings in Medicare and Medicaid spending cuts as well as other health spending reductions. If these savings are not achieved, the burden on families would be far greater, because the level of assured premium assistance would be far lower.

In the case of the Cooper/Breaux plan, even at its most generous levels, the Cooper/Breaux subsidy depends on deep discounts from health plans, even those plans selling at the lowest price in their Health Plan Purchasing Cooperatives (HPPC) area. However, federal funds available for low-income assistance may well be substantially less than the amount required to pay 90 percent of the lowest priced premium (the subsidy level that we have assumed in this study). In such a case, health plans would have to offer such deep discounts that it is highly unlikely that any plan would be able to afford to enroll subsidized patients. Many families would have to pay more out-of-pocket to find even a single plan that would accept them. Others would not be able to locate affordable insurance at all.

The Cooper plan also proposes to redefine poverty to a state-adjusted level and thus would lower the poverty threshold in many states. Families with incomes between 100 and 200 percent of the federal poverty level, who qualify for a subsidy and discount in our model, could find that they are unable to qualify for a subsidy at all under a revised definition of the federal poverty level. In addition, families with a member receiving Social Security Old Age Assistance or disability benefits would be required to declare those benefits as available to help meet other family members' health insurance needs, even if the Social Security benefits are not available for this purpose.

Part 2: <u>The Effect of Increased Work on Premium Assistance under the Plans</u>

Table 2 shows the effect of increased earnings on the amount of premium support available under the three premium-based plans. Just as in the case of basic premium support, the differences are striking. The President's bill is designed to maintain a substantial level of premium assistance for moderate income families and to avoid earnings "cliffs." Cliffs refer to the loss of premium assistance (subsidy) and the income over which the range occurs. The premium assistance in the President's plan is most visible as earnings increase as shown in Figure 3.

For example, at 100 percent of the poverty level a worker has health insurance premium payments under the President's plan equal to 3.0 percent of adjusted gross income (AGI). This percentage increases slightly to 3.9 percent of AGI at 150 percent of poverty (Table 1). Therefore, under the President's plan, a working mother whose pay increases from $11,890 (100 percent of poverty) to $17,835 (150 percent of poverty) would lose only 5.7 percent of her wage increase to higher premium payments under the President's plan; the dollar value of her additional premium payments would be $339 (Table 2). Because the President's plan assures substantial financial assistance with the cost of health insurance and does so for both lower and moderate income families, the measure's work incentive is strong.

The Thomas/Chafee and Cooper/Breaux measures, on the other hand, both

contain strong work penalties; the Cooper/Breaux bill is particularly punitive. Under the Thomas/Chafee bill, nearly $1,400 of our worker's $5,900 wage increase (over 23 percent of her wage increase) would be spent just to replace her lost health insurance subsidy. Stated differently, a pay raise that otherwise would raise her family's income to 150 percent of poverty would in fact leave her at only about 140 percent of poverty once her added insurance premiums were deducted. For every three steps forward, the Thomas/Chafee bill would exact another step back because the subsidy would drop so precipitously.

The drop is even more precipitous under the Cooper/Breaux bill, however. Moving from 100 percent of poverty to 150 percent of poverty will cost the wage earner in our example $1,950 in lost premium subsidies (Table 2). This represents about one dollar lost for every three additional dollars earned.

The work disincentives created by the Cooper/Breaux and Thomas/Chafee plans take on even greater significance when the "cliff" effect under these measures caused by increased earnings is combined with the wage earner's loss of the EITC as her wages increase Table 3. The EITC is a special negative income tax that provides low wage earners with a refundable tax credit in order to ensure that full-time work is rewarded, even if the worker's actual wages are low. As a worker's wages increase, the EITC is gradually phased out. Particular attention is paid to the "cliff" issue when the EITC is revised (as was the case in 1993), in order to avoid the creation of earnings disincentives.

As is shown on Table 3 and Figure 4, far from being mindful of the cliff, the Cooper/Breaux and Thomas/Chafee bills greatly exacerbate the problem. The first set of columns on Table 3 shows that a wage increase from 150 percent to 200 percent of poverty creates an EITC "cliff" of 19.3 percent. In other words, for every new dollar in earnings, our wage earner loses slightly more than 19 cents to the reduction in the EITC.

Tables 2 and 3 also show that under the President's bill, the cliff for this wage earner increases only slightly to 20.1 percent as a result of a 1.4 percent increase in premium payments as a percentage of family income. Virtually no additional family support is lost to increased health insurance premiums.

The Thomas/Chafee and Cooper/Breaux bills greatly exacerbate the EITC cliff, however. Under Thomas/Chafee, a wage increase from 150 to 200 percent of poverty results in a 23.4 percent loss in premium subsidies. Added to the 19 percent EITC cliff, the total loss to the wage earner is more than $4.00 for every $10.00 she earns.

The results for Cooper/Breaux are even greater. For every dollar in increased earnings, a worker moving from 150 percent of poverty to 200 percent

of poverty loses 30 percent in reduced health insurance premium assistance. When this loss is added to the EITC cliff, the worker in our example is faced with a 52 percent loss. For every ten dollars she earns, five dollars are immediately lost to a combination of the phased-out tax credit and higher health insurance premium costs.

The McDermott/Wellstone plan: Unlike the President's bill or the Cooper/Breaux and Thomas/Chafee bills, the McDermott/Wellstone plan provides public insurance financed through a payroll tax system plus a 2.1 percent tax on individuals' and families' taxable incomes. Table 4A shows the impact of the measure at different family income levels. At no point does a family earning under $48,000 pay more than 1.5 percent of family income for health coverage. Moreover, because the tax is levied on taxable income rather than adjusted gross income, families with incomes low enough to have no federal income tax liability (assuming application of the standard deduction) pay virtually nothing for coverage.

Table 4B shows that because family payments are low to begin with, as income increases, workers earning additional wages lose only between 1.9 percent and 2.1 percent of their additional earnings to increased tax liability for health coverage. Moreover, as shown in table 4C the bill creates virtually no additional "cliff" effect beyond the EITC cliff.

CONCLUSION

In designing a subsidy program, one is ultimately faced with a tradeoff: (1) to spread the public subsidy across a wider spectrum of low income families and individuals;[7] or (2) to focus the subsidy on families and individuals at the lowest end of the poverty spectrum.[8] President Clinton's plan adopts the first approach by requiring a nominal premium contribution from noncash families with very low incomes rather than providing a full subsidy to noncash families at or below poverty. As a result, the Clinton plan is able to extend an adequate level of guaranteed premium support to low and moderate income families across the poverty spectrum.

In contrast, the Thomas/Chafee and Cooper/Breaux plans support the second methodology by making coverage more affordable for families at or below the poverty level. As these families make gains in income, however, their insurance becomes less affordable. This study shows that only two bills -- the President's health reform plan and the plan sponsored by Representative McDermott and Senator Wellstone -- provide low and moderate income families with a sufficient level of guaranteed premium support to assure affordable coverage across the poverty continuum.

Without assured premium support, the vast majority of Americans who currently are either uninsured or else at risk for loss of coverage will derive little benefit from health reform. Of the more than 37 million Americans who were uninsured in 1992, over 30 million (82 percent) had family incomes below $40,000.[9] With numbers like these, coverage cannot possibly be guaranteed in the absence of affordable premiums. Without realistic payment mechanisms, other payers as well as the health system itself would continue to shoulder the burden of bad debt. It is this perverse result that health reform is in great part intended to avert.

Uninsured Americans, 84 percent of whom are workers and their family members, need an assurance of premium financial assistance. This assistance can come from numerous sources as the Health Security Act and the American Health Security Act show. But it most certainly cannot come from the families themselves

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[7] 61.6 million people are between 100 and 250 percent of poverty and 128.5 million people are between 250 and 400 percent of poverty, analysis of the March 1993 Current Population Survey by The Urban Institute, for the Kaiser Commission on the Future of Medicaid.

[8] 33.2 million people are below 100 percent of poverty, analysis of the March 1993 Current Population Survey by The Urban Institute, for the Kaiser Commission on the Future of Medicaid.

[9] Employee Benefit Research Institute, Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 1993 Current Population Survey (January 1994) p. 30.

without impoverishing them.

Moreover, no health insurance scheme should penalize work. In our opinion, to do so and thereby leave working Americans unable to afford coverage completely defeats any hope of meaningful welfare reform effort. Yet only the President's plan and the Wellstone/McDermott measure reward, rather than penalize, work. Both the Cooper/Breaux and Thomas/Chafee plans would make welfare reform extremely difficult to achieve, since their assistance formulas discourage, rather than foster, increased work effort.

The Cooper/Breaux plan has been advanced as a means of assuring universal access to insurance coverage. Yet the data presented in this study suggest that the bill would have only a very limited impact on coverage. Even the most optimistic assumptions about the effect of pure managed competition on insurance costs (as well as what we consider to be highly unrealistic assumptions under Cooper/Breaux about the amount by which even low priced plans can be further discounted for lower income persons) cannot reduce the cost of health insurance enough to make it affordable without an assured subsidy. Under the Cooper/Breaux plan, only the very poorest families would receive sizable assistance. Lower and moderate income working families potentially are left with thousands of dollars in health insurance premium costs to bear.

The Thomas/Chafee bill, while raising fewer problems for lower and moderate income families than the Cooper/Breaux plan, also leaves low and moderate income families without a sufficient level of assured premium assistance. The loss of the subsidy is more gradual under Thomas/Chafee proposal. Moreover, unlike the Cooper plan, Thomas/Chafee does not rely on large (and unlikely) health plan discounts below even levels charged by extremely efficient plans. Yet the Thomas/Chafee subsidy is not assured, and it is not sufficient to bring family premium costs down to realistic levels as both the President's plan and the Wellstone/McDermott plan do.

Several limitations in this study should be noted. First, we examine the effects of the proposals only on full-time workers. Unlike the other measures considered here, the President's proposal varies the level of financial support in several significant ways depending on whether families at the same income level derive all, some, or none of their income from work. Thus, for certain families, the level of assured premium support under the President's plan is greater than that shown in these tables. In other cases, the level is less.

For example, under the President's bill, persons whose incomes are derived solely from Aid to Families with Dependent Children (AFDC), Supplemental Security Income (SSI), or unemployment insurance would have 100 percent of their premiums paid. However, families whose incomes come from part-time

employment coupled with child support, Social Security Survivors' or Disability benefits or other non-exempt sources of unearned incomes could face premium payment responsibilities as high as 10 percent of their annual incomes. This higher exposure for part-time or non-working families with non-exempt income is the result of three separate factors: (a) the lack of an assured 80 percent employer contribution to the price of the premium; (b) the lack of exemptions for other forms of unearned incomes in the case of low income families; and, (c) the inapplicability of the 3.9 percent premium cap to families that are responsible not only for the 20 percent premium share but for unpaid portions of the 80 percent share as well.

The absence of assured premium support protections for all low income families -- not just those who work full time or who receive "exempt" income must be addressed. Not only is the lack of assured support harmful for families, but the absence of a uniform income-based policy toward treatment of family premium responsibilities could create major administrative confusion for both families, as well as for employers, health plans and state and federal governments. Family income levels and income sources can change frequently and literally overnight. A system capable of operating only with this degree of precision simply may not be workable.

A second limitation is that this study does not examine overall health plan affordability; only the issue of assured premium support is examined. Equally important to the issue of health care affordability are cost-sharing policies for insured families. If deductible and cost-sharing burdens are too great, utilization falls significantly -- and potentially harmfully[10] --in the case of those families without the resources to make out-of-pocket payments for health care. Thus, it would not be in the families' interest to address the premium affordability problem through the use of higher cost-sharing.

A final limitation is that we do not consider the long-term implications of various sources of assured family premium supports. Some have argued that to provide assured support through mandatory employer contributions would harm lower income workers because it would make their employment too expensive to maintain and would result in layoffs or job cutbacks. Yet any source of funding (whether derived directly from employers or from other revenue sources) will have some long-term effects. There is no good evidence showing that changes in the nature and mix of employer compensation that would result from mandatory contributions by employers will be either immediate or harmful. Indeed, there is reason to believe that through careful phase-in of a benefit design that relies on employer contributions with limits on premium burdens for small firms the effect on

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[10] United States Congress, Office of Technology Assessment. Benefit Design: Patient Cost Sharing (U.S. GPO, OTA-BP-H-112) September, 1993.

jobs will be modest.[11]

Even if cash wages were to fall slightly, the enormous and virtually immeasurable value of health insurance suggests that it is in families' interest to forego some speculative future cash wage increases in exchange for reliable and adequate health insurance coverage. Indeed, it is unlikely that well-insured and employed individuals today would be willing to exchange coverage (which is both tax exempt compensation and of intangible value) for a cash wage increase. The large number of labor disputes in recent years involving potential reductions in employer compensation for health insurance are a testament to the fundamental value of insurance as a form of employment compensation.

In sum, much attention has been paid to what is "on" or "off" the federal budget. In our opinion, the real budget that should count as Congress debates health reform is the family budget. This study shows that, regardless of whether we speak of "assuring" access or "guaranteeing" access, the basic task facing policy makers is selecting a financing approach that makes the promise real for families. No family with income below the federal poverty level should pay any portion of its insurance premium. Moreover, the level of assured support for near-poor and moderate income families must be sufficient to keep their premium burdens realistic. This means investing the resources necessary to assure affordability along the "glide slope" of family income.

Health reform should not pit the poor against near-poor and moderate income families as in the case of the Cooper/Breaux and Thomas/Chafee bills. Nor should near poor and moderate income families be asked to bear the burden of eliminating premium payments for poor families, as the President's bill requires. Sufficient funds should be invested to make coverage affordable for all families. Otherwise the principal objective of health reform will not be achieved.

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[11] United States Congressional Budget Office, An Analysis of the Administration's Health Proposal (February 8, 1994) pp. 61-67.

APPENDIX

Part 1: Assumptions for Each Bill

The Thomas/Chafee plan: In order to calculate the impact of the Thomas/Chafee bill on families the study made several assumptions.

- Assumption 1: Cost savings are sufficient to phase in the full subsidy program up to 240 percent of poverty. In the event that cost savings are not achieved, the bill provides for termination of the subsidy program at a lower income level. It is therefore possible that if no savings are achieved, the bill would provide no subsidy at all.

- Assumption 2: The program is fully phased in (the program is not scheduled for full phase-in until the year 2005). Enough savings have occurred to implement the full subsidy range (the Thomas/Chafee subsidy is available only to the extent that there are savings to pay for it).

- Assumption 3: The average premium used in this study in fact is low enough to fall within the lower half of all premiums offered in the representative families' health care coverage area. Were the hypothetical premium to exceed this level, the relative value of the Thomas/Chafee family subsidy would be overstated. For example, if the lower average cost premium in the family's health care coverage area is $3,300 rather than $3,900, as in the study, the voucher value would be lower and the family's out-of-pocket responsibilities greater if it selects the hypothetical plan.

President Clinton's plan: In order to calculate the effects of the President's formula on families, we made the additional assumptions.

- Assumption 1: The premium used equals the average weighted premium for the alliance in which the family is enrolled. In the case of premiums exceeding the average weighted premium the family share would equal 20 percent plus the entire difference up to the actual price of the plan (that is, there would be no mandatory employer contribution beyond the average weighted premium).

- Assumption 2: The worker in our example is employed on a full -time basis and therefore qualifies for an employer contribution of 80 percent of the average weighted premium. (If the worker were employed on a part-time basis, additional government assistance would be available under a separate formula in the event that his or her unearned income did not exceed 250 percent of the federal poverty level).

- Assumption 3: The family is enrolled in a regional alliance health plan.

The Cooper/Breaux plan: In order to calculate the effect of the Cooper/Breaux bill on families we made the following assumptions.

- Assumption 1: The premium used is the lowest priced premium. The family therefore has selected a health plan whose cost does not exceed the lowest priced plan for the HPPC in which it resides.

- Assumption 2: The family's income is its family adjusted income and no one in the family receives Social Security.

- Assumption 3: The discounted price for lower income families amounts to 90 percent of the lowest priced premium (this figure is relatively representative of Medicaid price discounting today, although it may be somewhat generous).

- Assumption 4: The federal poverty level is the applicable poverty level. In a state with an applicable poverty level that is either higher or lower than the federal poverty level the dollar value of both health plan discounts and direct subsidies also would change.

- Assumption 5: The families do not itemize their tax deductions and thus do not qualify for the added incremental value of the new deduction for health plan purchases in the bill.

The McDermott/Wellstone plan: For the purpose of calculating the impact of McDermott/Wellstone plan on families, the study assumed the following.

- Assumption 1: The families have no excess unearned income.

- Assumption 2: The family income levels shown are their earnings.

Part 2: Premium Assistance Formulas

The Thomas/Chafee Plan: The federally-administered voucher program is fully phased-in by year 2005, shown in Table 1 below.

Table 1

Calendar Year	Phase-in Percentage
1997	90 % of poverty
1998	110 % of poverty
1999	130 % of poverty
2000	150 % of poverty
2001	170 % of poverty
2002	190 % of poverty
2003	210 % of poverty
2004	230 % of poverty
2005	240 % of poverty

The voucher percentage is shown in Table 2 below.

Table 2

Year	Poverty Level	Voucher percentage [100 - ((percentage above 100) X (100/140))]
1997	90	100 percent
1998	110	93 percent
1999	130	79 percent
2000	150	64 percent
2001	170	50 percent
2002	190	36 percent
2003	210	21 percent
2004	230	7 percent
2005 *	240	0

* In 2005, at full phase-in, each of the previous percentages would continue to apply.

The Thomas/Chafee plan provides a tax deduction only if filers itemize their medical and dental expense deduction.

- The deduction is available regardless of whether the cost of the plan exceeds 7.5% of AGI.
- The deduction is available for any portion of the qualified health plan paid by the enrollee (does not have to pay the entire cost).
- The deduction is taken against gross income instead of AGI.
- The deductibility of the premium is capped at the average cost of the lowest priced one-half of certified plans in an area.

- The deduction is available only if the purchase is actually made and thus is of limited use to lower income families who cannot afford the purchase.

President Clinton's Plan: In order to calculate the effects of the President's formula on families, we assumed the following.

- Amount of premium paid by a full-time employed family member enrolled through a regional alliance = 20% of average weighted premium.

- Families with taxable incomes (AGI) below 150 percent of poverty get a discount on the family share equal to the following:

  - full discount if AGI < $1000 income or receiving AFDC or SSI (not applicable in our model).

  - 20% family share capped at 3.9% of AGI, if AGI is > 150% of poverty but < $40,000.

  - no cap on 20 percent family share if income exceeds $40,000.

  - if family's AGI is > $1000 but <150% of poverty for family of that size, then family pays the SUM of (a) and (b):

    a. Initial marginal rate is: [(3% of 100% of the poverty level) divided by (100% of the federal poverty level minus $1,000)] . The initial marginal rate then is multiplied by (100% of the federal poverty level for family size minus $1,000).

    b. Final marginal rate is: [((the 20% family share) minus (3% of 100% of the federal poverty level)) divided by (50% of 100% of the federal poverty level)]. The final marginal rate then is multiplied by (the family's AGI minus 100% of the federal poverty level for a family of that size).

The Cooper/Breaux Plan: The subsidy for low-income persons (with family incomes <200% of poverty) works described below.

- A mandatory discount is provided by accountable health plans.

- Direct federal payment (known as a federal assistance amount) is paid

to the plan for very low and moderately low-income persons.

The federal subsidy is related to (but presumably less than) the reference premium which is also the measure used to determine the cap on the employee tax exclusion. The reference premium is the lowest premium in the HPCC area (by premium class) that is offered by an open AHP (one not limited to large employers) and which enrolls a threshold proportion of HPCC members. The threshold is set by the Commission. (We assume that the threshold rule is to avoid using as the reference premium an amount charged by a plan that virtually no one selects).

Since the tax exclusion for workers with employer contributions is related to the reference premium, this means that for workers with contributing employers, the maximum income exclusion is equal to the lowest priced health plan in which a certain percentage of eligible persons enroll. This enrollment threshold could be set high or low, depending on how strict the Commission wants to be on the value of the tax exclusion.

In addition to the allowable employer contribution on a tax excluded basis, the Cooper/Breaux bill adds for persons itemizing medical expenses a new deduction for AHP premium expenses. A description of the tax deduction is provided after the calculations for the subsidy program.

The calculations used in the Cooper/Breaux bill are described in steps one through three.

Step 1. Calculate the AHP discount price (premium adjustment) for low-income persons.

AHPs (whether closed or open), must discount their premiums for very low (<100% of poverty) and moderately low income (100%-200% of poverty). Income in this case is defined as family adjusted total income. This income level equals (a) AGI plus (b) tax exempt interest plus (c) Social Security income normally exempt from gross income. The term "low income" would no longer mean the federal poverty level, but would instead equal the state-adjusted poverty level. The sum total of all state adjusted poverty levels may not exceed 1.

In the case of very low-income persons (<100% of poverty), the discount on the AHP's charge equals the following :

- [(the base federal premium amount) + (10% of the amount by which the AHP premium exceeds the reference premium)].

    - The base federal premium amount: This amount is equal to [(the reference premium rate) x (national subsidy percentage)].

Thus, if the national subsidy percentage equalled 100%, the base federal premium amount would equal the reference premium. Conversely, since there is no floor on the national subsidy percentage, the base federal premium could fall dramatically below the reference premium. We assume that this possibility intentionally has been left open under Cooper/Breaux, since otherwise the subsidy would have been at the reference rate amount.

The national subsidy percentage equals the total amount available to spend on federal assistance (capped mandatory spending) divided by the amount that would be spent if the subsidy amount equalled to reference premium rate. This amount is expressed as a percentage. Thus, if the reference premium is $4,000 but funds are available to pay only 85% of this amount, then the base federal premium would be set at 85% of the reference premium. There is no statutory floor on the national subsidy, although there appears to be a ceiling.

The individual's applicable federal assistance amount (the actual subsidy) is then credited against this amount owed.

Thus, if the AHP's premium is at the reference premium amount, it would simply charge the base federal premium amount. If the AHP premium is over the reference premium, then the discounted charge would be the federal premium amount plus 10% of the difference between the AHP premium and the reference premium for the HPCC.

In the case of moderately low-income persons (100-200% of poverty), the discounted charge equals the sum of (a) and (b).

(a) [(the applicable low-income premium amount)

+

(b) ((the greater of either the individual responsibility percentage or 10 percentage points) x (the amount by which the AHP premium exceeds the reference premium))].

As with very low-income persons, the plan must credit the federal premium assistance subsidy amount against its discounted price in determining what the person owes.

Since the federal premium amount is potentially less than the reference premium, the federal assistance cap for very low-income persons is potentially less than the reference premium.

Step 2. Calculate the applicable federal assistance amount.

To calculate the actual federal premium assistance amount for very and moderately low-income persons, the following steps are required.

The applicable federal assistance amount subsidy for low-income persons is expressed as follows:

- For a very low-income person the assistance amount is equal to the base Federal premium amount. Thus, a very low-income person would owe nothing unless the plan selected had a price higher than the federal premium amount. Conversely, a very low-income individual will always pay something if the plan they chose charged more than the reference premium. (In our case we posited that the family chose a plan that charged the reference premium rate by assuming that the average priced plan equalled the reference premium.)

- For a moderately low-income person, the federal assistance amount equals the following: [(applicable low-income premium amount) - (base individual premium)].

  - The applicable low-income premium amount equals the sum of (a) and (b):

    (a) [(the base Federal premium amount)
    +
    (b) ((the individual responsibility percentage) x (reference premium rate minus the base Federal premium amount))].

  - The base individual premium equals the following:

    - [(the individual responsibility percentage) x (the reference premium rate)].

  - The individual responsibility percentage equals:

    - 0 percentage points for very low-income persons; and

    - for moderately low-income persons, the individual responsibility equals the number of percentage points greater than the applicable poverty level.

Step 3. Calculate what the family pays.

In figuring out how much to actually collect from the individual, the AHP would subtract the federal assistance amount from this discounted price.

The Cooper/Breaux plan provides a tax deduction only if filers itemize their medical and dental expense deduction.

- The deduction is available regardless of whether the cost of the plan exceeds 7.5% of AGI.
- The deduction is available for any portion of the AHP paid by the enrollee (does not have to pay the entire cost).
- The deduction is taken against gross income instead of AGI.
- The deductibility of the premium is capped at the lowest priced plan in the alliance.
- The deduction is not available unless coverage is bought through an alliance. Therefore, employees of large employers (with more than 100 employees) are not eligible for the deduction.
- The deduction is available only if the purchase is actually made and thus is of limited use to lower income families who cannot afford the purchase.
- The deduction would reduce the cost of insurance only by a portion. Assuming that an average plan costs $4,400 and the low priced plan costs $4,000, then the deduction is capped at $4,000. Moreover, if the person chose the $4,500 plan the real cost of the plan would still be about $3,400, assuming the individual is in a 28% tax bracket and takes the $4,000 deduction.

The McDermott/Wellstone Plan:

Financing for coverage is derived from a number of sources, including a payroll tax and an increase in individual and corporate taxes. For individuals, the principal tax increases are shown below.

Payroll tax:

- Employer (large) 8.4%
- Employer (small) 4.0%

Income tax:

- 2.1 percent is applied against taxable income rather than adjusted gross income

Table 1

ANNUAL PREMIUM ASSISTANCE FOR LOW AND MODERATE INCOME WORKING FAMILIES UNDER SELECTED PREMIUM-BASED HEALTH REFORM PROPOSALS

Family Chooses Average-Priced Health Insurance Plan ($3,900)[1]

Poverty and Income Levels		Clinton/Gephardt/Mitchell HR 3600/S 1757					Thomas/Chafee HR 3704/S 1770					Cooper/Breaux HR 3222/S 1579				
Poverty Level	Family[2] Income[3]	Subsidy	Firm Pays	Plan Pays	Family Pays	% of Family Income	Subsidy[6]	Firm Pays	Plan Pays	Family Pays	% of Family Income	Subsidy[7]	Firm Pays[8]	Plan Pays	Family Pays	% of Family Income
100	11,890	423	3120	0	357	3.0	3900	0	0	0	0	3510	0	390	0	0
130	15,457	177	3120	0	603	3.9	3064	0	0	836	5.4	2457	0	273	1170	7.6
150	17,835	84	3120	0	696	3.9	2507	0	0	1393	7.8	1755	0	195	1950	10.9
180	21,402	0	3120	0	780	3.6	1671	0	0	2229	10.4	702	0	78	3120	14.6
200	23,780	0	3120	0	780	3.3	1114	0	0	2786	11.7	0	0	0	3900	16.4
250	29,725[4,5]	0	3120	0	780	2.6	0	0	0	3900	13.1	0	0	0	3900	13.1
300	35,670	0	3120	0	780	2.2	0	0	0	3900	10.9	0	0	0	3900	10.9
400	47,560	0	3120	0	780	1.6	0	0	0	3900	8.2	0	0	0	3900	8.2

[1] Based on CBO's estimate of the 1994 average premium cost ($4,095) of a health insurance plan for a one-adult family, deflated to 1993 dollars by assuming 5% growth in the medical component of the CPI

[2] Family of three; full-time working mother with two dependent children; not receiving AFDC or SSI

[3] Federal poverty guidelines for 1993; adjusted gross income

[4] Median income for all households in 1991 was $30,126, Statistical Abstract of the U.S., 1993; 61.6 million people are between 100 and 250% of poverty and 128.5 million people are between 250 and 400% of poverty, Analysis of the March 1993 Current Population Survey by The Urban Institute, Kaiser Commission on the Future of Medicaid

[5] 16.3 million uninsured or 43% are between 100 and 250% of poverty, Analysis of the March 1993 Current Population Survey by The Urban Institute, Kaiser Commission on the Future of Medicaid

[6] Assumes full phase-in of subsidy program

[7] Calculated assuming 90% national subsidy and reference premium is equal to average premium

[8] Assumes no voluntary employer contribution toward cost of premium

Table 2

IMPACT OF ANNUAL PREMIUM ASSISTANCE UNDER SELECTED PREMIUM-BASED HEALTH REFORM PROPOSALS ON LOW AND MODERATE INCOME FAMILIES AS THEY INCREASE INCOME

Family Chooses Average-Priced Health Insurance Plan ($3,900)[1]

Poverty and Income Levels		Clinton/Gephardt/Mitchell HR 3600/S 1757		Thomas/Chafee HR 3704/S 1770		Cooper/Breaux HR 3222/S 1579	
Change in Income as a Percent of Poverty[2]	Dollar Amount of Increase in Income	Dollar Amount of *Additional* Increase in Annual Premium Liability for Family	Percent of Wage Increase Devoted to Annual Premium	Dollar Amount of *Additional* Increase in Annual Premium Liability for Family	Percent of Wage Increase Devoted to Annual Premium	Dollar Amount of *Additional* Increase in Annual Premium Liability for Family	Percent of Wage Increase Devoted to Annual Premium
100 → 150	5,945	339	5.7	1393	23.4	1950	32.8
130 → 180	5,945	177	3.0	1393	23.4	1950	32.8
150 → 200	5,945	84	1.4	1393	23.4	1950	32.8
200 → 250	5,945	0	0	1114	18.7	0	0

[1] Based on CBO's estimate of the 1994 average premium cost ($4,095) of a health insurance plan for a one-adult family, deflated to 1993 dollars by assuming 5% growth in the medical component of the CPI

[2] The Federal poverty level is used for a family with 3 persons, including a mother with two dependent children

Table 3

IMPACT OF ANNUAL PREMIUM ASSISTANCE UNDER SELECTED HEALTH REFORM PROPOSALS AND EARNED INCOME TAX CREDIT (EITC) ON LOW AND MODERATE INCOME FAMILIES AS THEY INCREASE INCOME

Family Chooses Average-Priced Health Insurance Plan ($3,900)[1]

Effect of Increased Income on EITC				Clinton/Gephardt/Mitchell HR 3600/S 1757			Thomas/Chafee HR 3704/S 1770			Cooper/Breaux HR 3222/S 1579		
Change in Income as a Percent of Poverty[2]	Dollar Amount of Increase in Income	Dollar Amount Reduction in EITC[3,4]	Percent of New Earnings Lost to Reduced EITC	Dollar Amount of Increase in Annual Premium Liability for Family	Total Income Lost to Extra Premium Liability and Reduced EITC	Percent of New Earnings Lost to Extra Premium Liability and Reduced EITC	Dollar Amount of Increase in Annual Premium Liability for Family	Total Income Lost to Extra Premium Liability and Reduced EITC	Percent of New Earnings Lost to Extra Premium Liability and Reduced EITC	Dollar Amount of Increase in Annual Premium Liability for Family	Total Income Lost to Extra Premium Liability and Reduced EITC	Percent of New Earnings Lost to Extra Premium Liability and Reduced EITC
100 → 150	5945	1146	19.3	339	1485	25.0	1393	2539	42.7	1950	3096	52.1
130 → 180	5945	1146	19.3	177	1323	22.3	1393	2539	42.7	1950	3096	52.1
150 → 200	5945	1146	19.3	84	1230	20.1	1393	2539	42.7	1950	3096	52.1
200 → 250	5945	621	10.4	0	621	10.4	1114	1735	29.2	0	621	10.4

[1] Based on CBO's estimate of the 1994 average premium cost ($4,095) of a health insurance plan for a one-adult family, deflated to 1993 dollars by assuming 5% growth in the medical component of the CPI

[2] The Federal poverty level is used for a family with 3 persons, including a mother with two dependent children

[3] The Earned Income Tax Credit assumes full phase-in but is deflated to 1993 dollars by assuming 3% growth in the CPI

[4] Family qualifies for 2 or more child credit

Table 4A

OUT-OF-POCKET COSTS FOR HEALTH CARE FOR LOW AND MODERATE INCOME WORKING FAMILIES UNDER THE MCDERMOTT/WELLSTONE (HR 1200/S 491) HEALTH REFORM PROPOSAL

Poverty Level	Family[1] Income[2]	Subsidy	Firm Pays	Plan Pays	Family Pays[3,4]	% of Family Income
100	11,890	n/a	n/a	n/a	0	0
130	15,457	n/a	n/a	n/a	62	.4
150	17,835	n/a	n/a	n/a	112	.6
180	21,402	n/a	n/a	n/a	187	.9
200	23,780	n/a	n/a	n/a	237	1.0
250	29,725[5,6]	n/a	n/a	n/a	362	1.2
300	35,670	n/a	n/a	n/a	487	1.4
400	47,560	n/a	n/a	n/a	736	1.5

[1] Family includes a mother with two dependent children

[2] Federal poverty guidelines for 1993; adjusted gross income

[3] A 2.1 percent tax on taxable income is assessed on all families

[4] Family qualifies for a standard deduction of $12,500; income is not taxable until this threshold is reached

[5] Median income for all households in 1991 was $30,126, Statistical Abstract of the U.S., 1993; 61.6 million people are between 100 and 250% of poverty and 128.5 million people are between 250 and 400% of poverty, Analysis of the March 1993 Current Population Survey by The Urban Institute, Kaiser Commission on the Future of Medicaid

[6] 16.3 million uninsured or 43% are between 100 and 250% of poverty, Analysis of the March 1993 Current Population Survey by The Urban Institute, Kaiser Commission on the Future of Medicaid

Table 4B

TAX LIABILITY UNDER THE MCDERMOTT/WELLSTONE (HR 1200/S 491) HEALTH REFORM PROPOSAL FOR LOW AND MODERATE INCOME WORKING FAMILIES AS THEY INCREASE INCOME

Change in Income as a Percent of Poverty[1]	Dollar Amount of Increase in Income	Dollar Amount of *Additional* Increase in Tax Liability[2] for Family[3]	Percent of Wage Increase Devoted to Tax Liability[2]
100 → 150	5,945	112	1.9
130 → 180	5,945	125	2.1
150 → 200	5,945	125	2.1
200 → 250	5,945	125	2.1

[1] The Federal poverty level is used for a family with 3 persons, including a mother with two dependent children

[2] A 2.1 percent tax on taxable income is assessed on all families

[3] The family qualifies for a standard deduction of $12,500; therefore income is not taxable until this threshold is reached

Table 4C

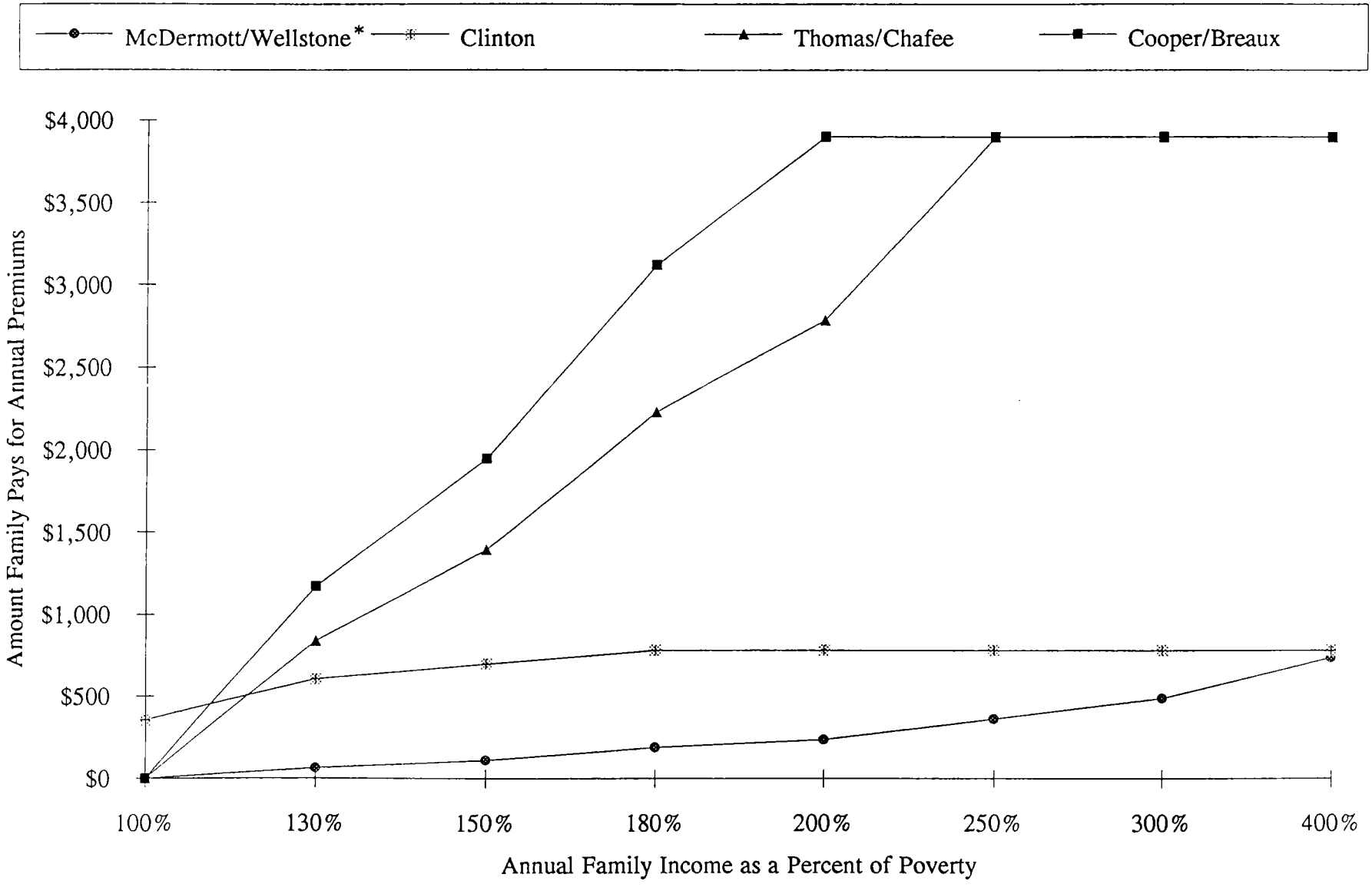
IMPACT OF TAX LIABILITY UNDER THE MCDERMOTT/WELLSTONE (HR 1200/S 491) HEALTH REFORM PROPOSAL AND THE EARNED INCOME TAX CREDIT (EITC) ON LOW AND MODERATE INCOME FAMILIES AS THEY INCREASE INCOME

Change in Income as a Percent of Poverty[1]	Dollar Amount of Increase in Income	Dollar Amount Reduction in EITC[2,3]	Percent of New Earnings Lost to Reduced EITC	Dollar Amount of Increase in Annual Tax[4] Liability for Family[5]	Total Income Lost to Extra Tax Liability and Reduced EITC	Percent of New Earnings Lost to Extra Tax Liability and Reduced EITC
100 → 150	5945	1146	19.3	112	1258	21.2
130 → 180	5945	1146	19.3	125	1271	21.4
150 → 200	5945	1146	19.3	125	1271	21.4
200 → 250	5945	621	10.4	125	746	12.5

[1] The Federal poverty level is used for a family with 3 persons, including a mother with two dependent children
[2] The Earned Income Tax Credit assumes full phase-in but is deflated to 1993 dollars by assuming 3% growth in the CPI
[3] Family qualifies for 2 or more child credit
[4] A 2.1 percent tax on taxable income is assessed on all families
[5] The family qualifies for a standard deduction of $12,500; income is not taxable until this threshold is reached

Figure 1

AMOUNT SPENT ON ANNUAL PREMIUMS UNDER SELECTED HEALTH REFORM PROPOSALS
Low to Moderate Income Working Family Chooses Average-Priced Premium ($3,900)

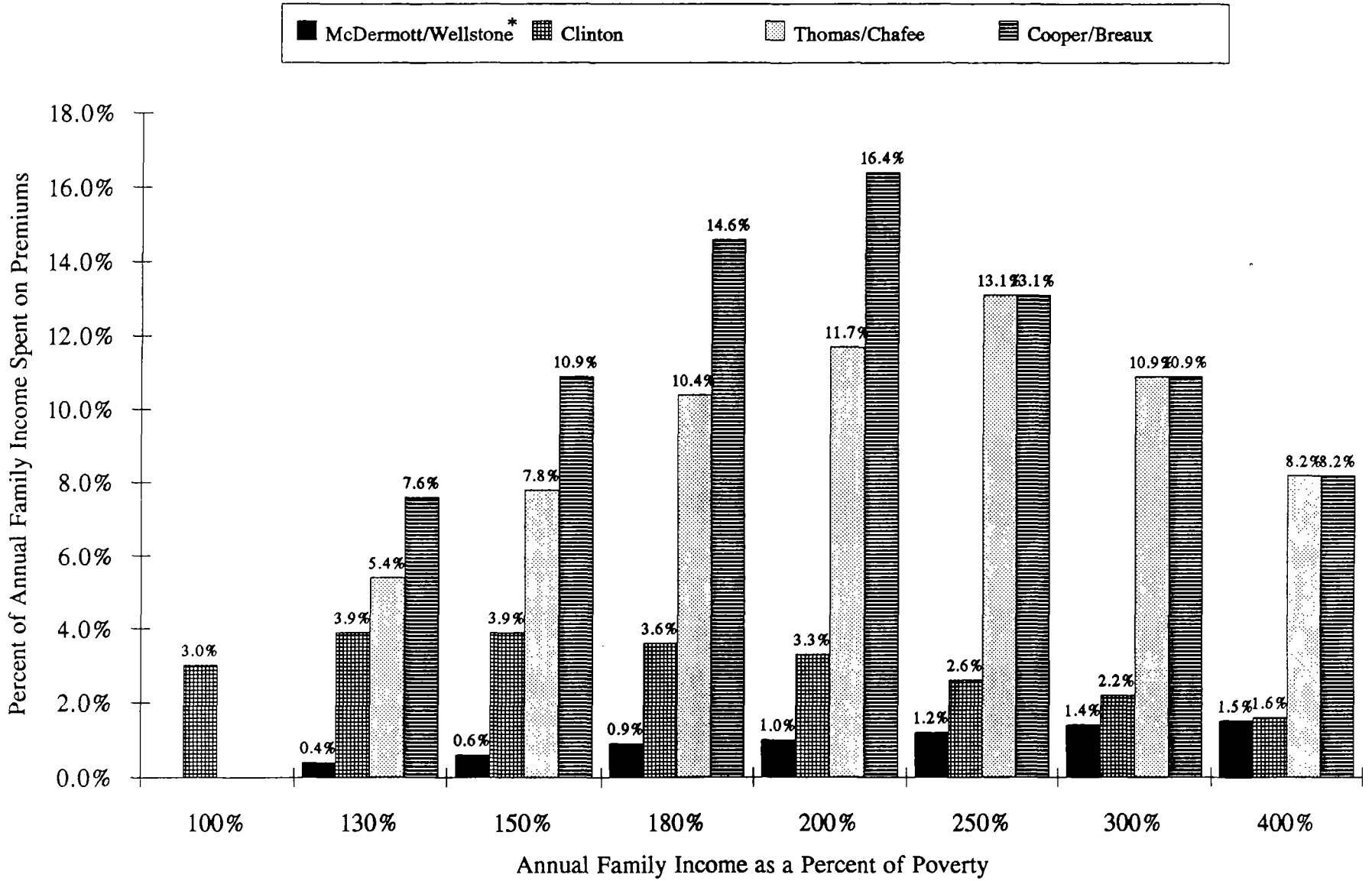


* For the McDermott/Wellstone proposal, families must pay a 2.1% tax on taxable income instead of a premium

Figure 2

PERCENT OF ANNUAL FAMILY INCOME SPENT ON PREMIUMS UNDER SELECTED HEALTH REFORM PROPOSALS

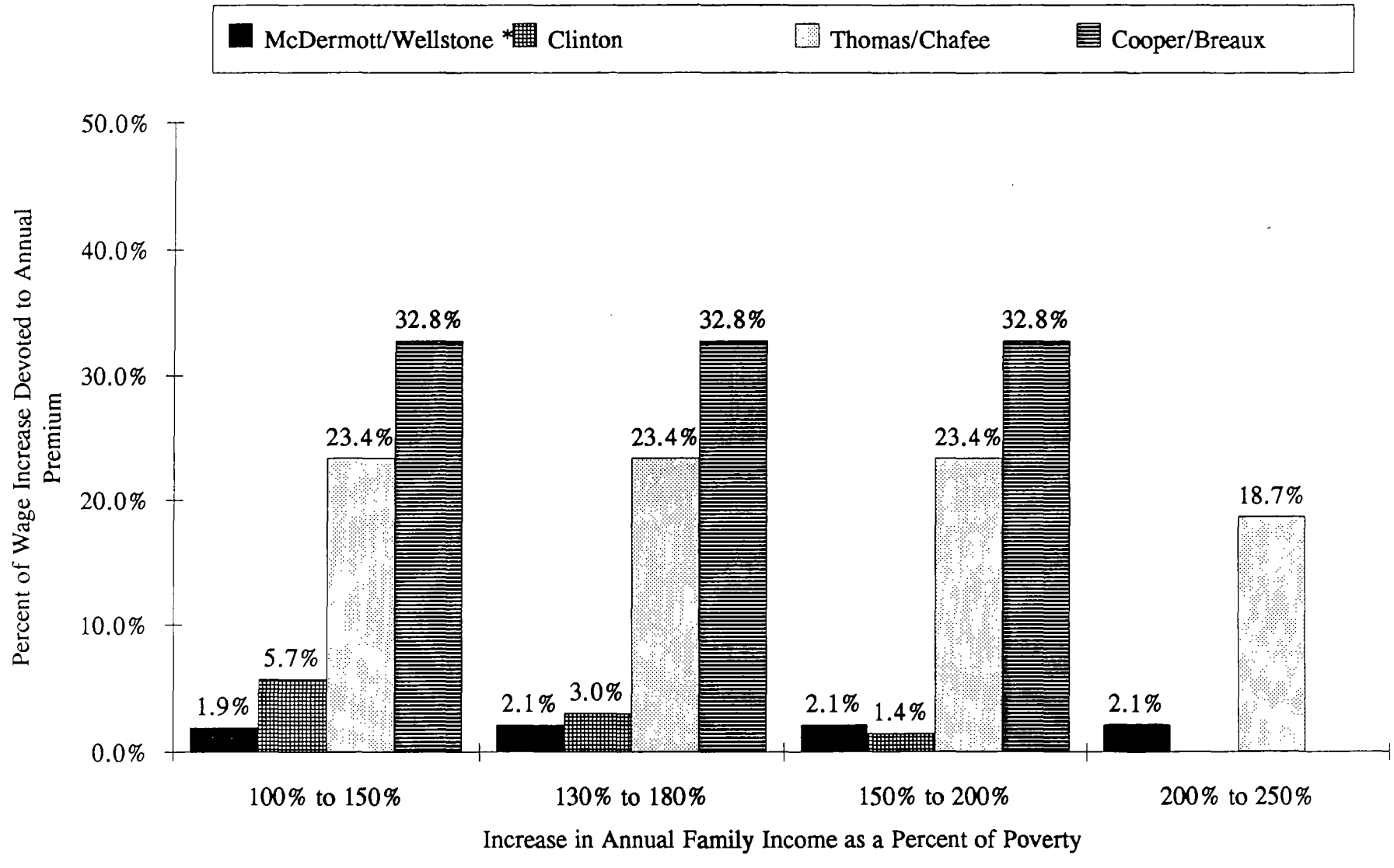
Low to Moderate Income Working Family Chooses Average-Priced Premium ($3,900)



* For the McDermott/Wellstone proposal, families must pay a 2.1% tax on taxable income instead of a premium

Figure 3

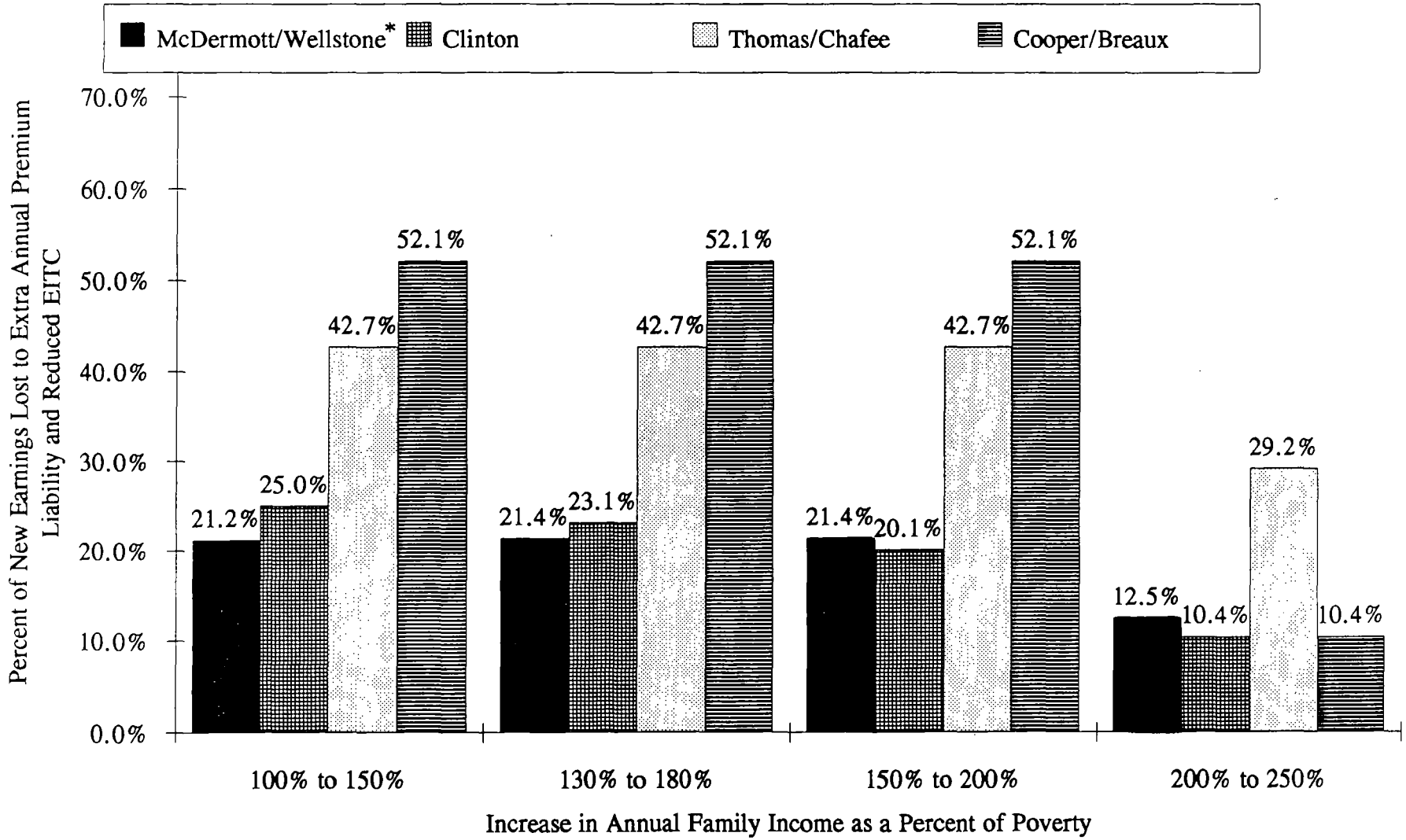
PERCENT OF WAGE INCREASE DEVOTED TO ANNUAL PREMIUMS UNDER SELECTED HEALTH REFORM PROPOSALS FOR LOW AND MODERATE INCOME FAMILIES AS THEY INCREASE THEIR INCOME



* For the McDermott/Wellstone proposal, families must pay a 2.1% tax on taxable income instead of a premium

Figure 4

PERCENT OF WAGE INCREASE DEVOTED TO ANNUAL PREMIUMS UNDER SELECTED HEALTH REFORM PROPOSALS AND LOSS OF EARNED INCOME TAX CREDIT FOR LOW AND MODERATE INCOME FAMILIES AS THEY INCREASE THEIR INCOME



* For the McDermott/Wellstone proposal, families must pay a 2.1% tax on taxable income instead of a premium