MEMORANDUM

To: Robert Rubin, Kim O'Neil

From: David T. Ellwood

Subject: Medicaid for Welfare Swap

I enclose a draft of the materials you requested on a swap. I was unsure what format you wanted. I also enclose copies of some charts/tables which were used in the swap discussion. These could accompany the material and would aid in understanding. However, I have written the text in such a way that these charts are not necessary (just helpful). Finally I wrote 3 pages rather than 2. Since both health and welfare issues are involved in the swap, I found it very hard to get the text down to 2 pages. If you believe it essential that the length be reduced, I will do so this morning. One last item. I'm asking a few people to check the material for accuracy and content, so I might seek to make minor changes in these materials. Let me know if you need any further help.

Swapping Medicaid for AFDC, Food Stamps, and WIC

Overview

Over a period of many years, the idea of "swapping" Medicaid for welfare has been proposed at various times. President Reagan proposed such a swap. Most recently, Nancy Kassebaum is pushing a swap proposal. The analysis here is based on the Kassebaum proposal of last year which is currently under revision. The proposal in its simplest form really is a full federal takeover of Medicaid in exchange for leaving the full responsibility for AFDC (including JOBS), Food Stamps, and the WIC program to the states. States would be completely relieved of fiscal costs (and presumably administration) of Medicaid.

Supporters of the idea argue that it sorts out responsibility for two programs which currently suffer from an overly complex joint federal state relationship. By making Medicaid national, we move toward a more uniform system where the federal government already has considerable experience from Medicare. And, supporters argue, states and localities can best determine the appropriate way to serve the more employable poor who do not qualify for SSI. Such a change would have dramatic impacts fiscally on both the federal and state governments and even more profound impacts on non-medical support for the poor.

Though the notion of clearly sorting out state and federal roles had some appeal, after discussion the participants were skeptical of the swap idea because of its adverse fiscal and social policy implications.

Federal Fiscal Implications of a Swap

A full swap has dramatic implications for the federal budget. Any proposal would call for a gradual phase in period, but one can examine what the implications of a full and immediate swap by looking at current budget projections.

In 1996, the federal welfare programs included in the Kassebaum proposal were expected to cost the federal government $48 billion. State Medicaid expenditures are expected to be $78 billion. (The swap was originally championed at a time when the Medicaid and welfare costs were much closer.) Thus even in 1996, a pure swap would cost $30 billion federal, if the federal government covered exactly the same people as states currently cover and reimbursed in exactly the same way as the states do now. Worse still, because Medicaid costs are growing much faster than welfare costs, the gap rises rapidly over time reaching over $100 billion annually in a decade. Over a ten year period the total gap would amount to $640 billion.

Given these fiscal realities, the only way to make a swap work without breaking the budget would be to swap more welfare programs or only a portion of Medicaid for welfare. The most practical plan may be to swap welfare for Medicaid acute care services, leaving the current long term care portion as the shared state/federal Medicaid it is today. Such a plan would be roughly budget neutral over the 5 year budget window, with states facing somewhat higher costs initially and saving money in the out years. But since Medicaid costs rise so

much faster than welfare, in the second 5 years, such a plan would cost the federal government would still be $120 billion.

There is reason to believe that these costs are understated. Under a federalized Medicaid program, the federal government would almost certainly be forced toward greater uniformity of reimbursement rates. If costs were to remain constant at their current level, rates would have to decreases in some states and increase in others. More likely there would be pressure to increase rates at least to the Medicare levels which would increase the cost per participant by 10-15%. And since one could no longer link Medicaid coverage to AFDC eligibility (there would be no AFDC program), a whole new federal system of eligibility would have to be created. Current Medicaid eligibility rules vary greatly among states, thus in moving to a uniform federal system, the only way to keep the number of participants (and costs) from increasing would be to reduce eligibility in some states while increasing it in others.

State Fiscal Implications of a Swap

If one adopted a welfare for acute care swap whereby the states overall roughly broke even in the first 5 years, and were net winners in the second 5, a second problem arises: the fiscal implications state by state are highly variable. In the year 2002, in aggregate states would gain nearly $19 billion from the swap. Some states like California ($4 billion annual savings) would be huge winners, since their Medicaid programs are much more expensive than welfare. But other states, such as Mississippi and Texas, would be big losers because their Medicaid costs are so significantly lower than the lost federal share of AFDC and food stamps. In the case of Mississippi, the loss of federal welfare benefits would be more than double the savings in Medicaid, even in 2002.

Unfortunately, because the plan calls for a full swap of one set of responsibilities for another, there is no good way to adjust the distributional implications across states--there are no formulas or grants which could be changed. In general, low income states which currently have a high federal match and low AFDC benefit levels would not get enough Medicaid savings to fund equivalent welfare programs even if they chose to do so.

Implications of a Swap for Welfare

This proposal represents a profund shift in the philosophy of support for the poor. Given the very large variation in fiscal capacity and need across states, the federal government has always played a major role in the financing of low income programs. In aggregate a combined 80% of the money for the programs proposed for swaps currently comes from the federal government. Those payments would all end.

It is critical to distinguish this swap proposal from block grant proposals which are incorporated in some Republican welfare reform plans. In a block grant the federal government continues to provide resources and could, in principle, include some conditions on states for the receipt of the those resources. Under a swap, the federal government gets out of the welfare business altogether. Both the level of resources devoted to supporting the poor and the rules associated with receipt would be entirely left to the states.

If such a swap were adopted, it would immediately end any federal role in welfare reform, since no federal dollars would be involved. It would quite literally be an end to welfare reform in the Congress. A swap brings the obvious advantage of dramatically increased flexibility for states, but since it also implies an end to any federal financial particpation or any uniform standards at all, the flexibility comes at a significant cost.

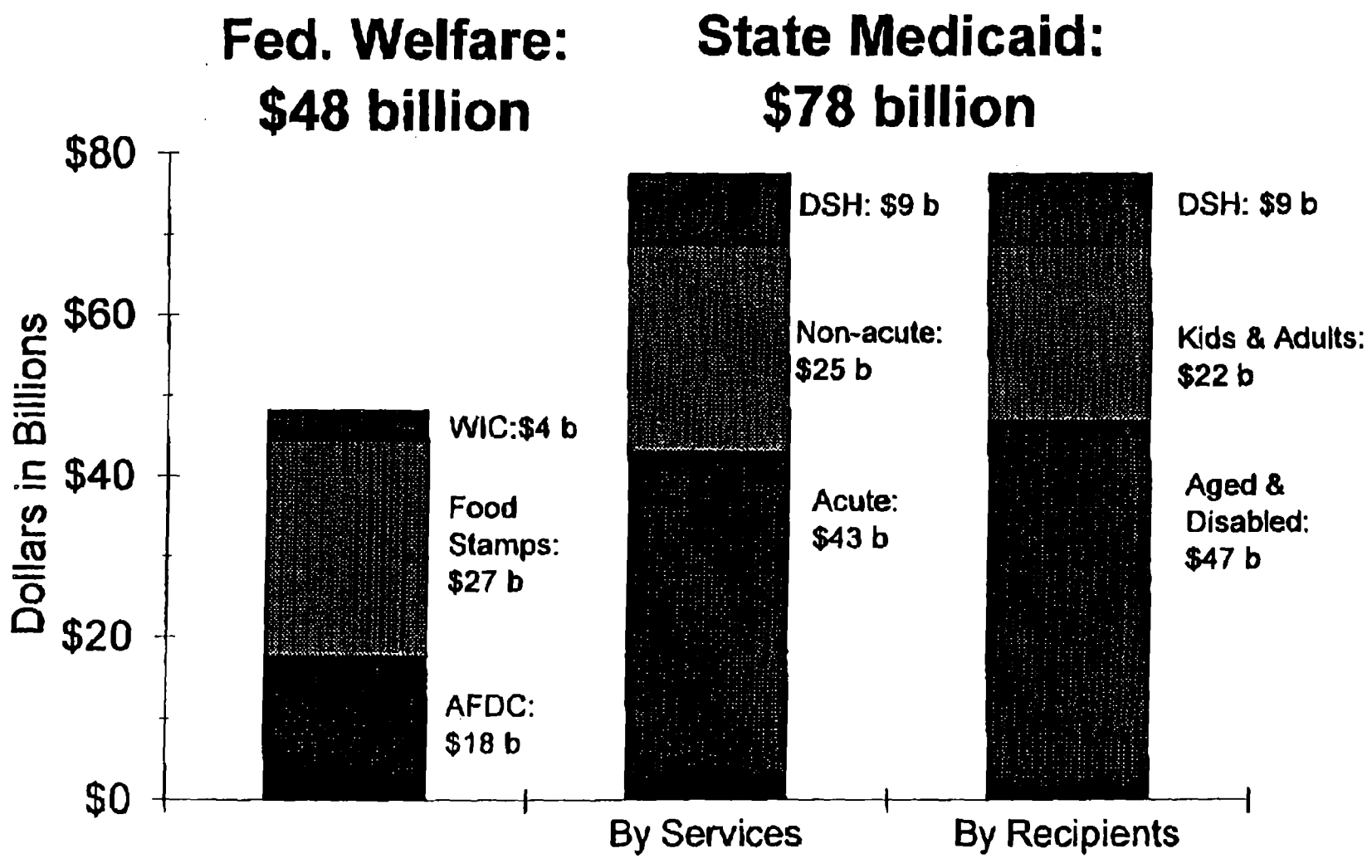
First, the loss of a uniform national food stamp system and the federal support for AFDC could be devastating both to low income families and to the fiscal health of states during recessions. Food stamps is the only real national safety net. Its uniform eligibility rules seek to ensure that no American need go hungry. It helps to fill in the gaps in AFDC benefit levels across states, since food stamps are larger when AFDC benefits are lower. And both food stamps and AFDC serve as automatic stabilizers in times of recession.

In a state like Mississippi, the federal government pays 80% of AFDC costs and 100% of food stamp costs. Thus out of a combined AFDC plus food stamp benefit of $415 per month for a family of three (less than half the poverty line), Mississippi actually only contributes $25. Even if Mississippi were to save $395 per family in Medicaid costs each month, it seems questionable whether they would reinvest the entire savings to support for low income families rather than using the freed resources for more spending on schools or roads or tax cuts. In fact, because its Medicaid expenditures are low, even in later years Mississippi would actually only save about $200 per family by swapping away Medicaid and thus could not invest in the same level of food and income support even it chose to do so.

Food stamps' equilizing effect across states would also be lost. The amount of food stamps a family on AFDC gets in Mississippi is actually considerably higher than an AFDC family in Connecticut because AFDC cash benefits are so much higher in the latter that recipients qualify for less food aid. Looking at the variation in AFDC benefits alone, there is a ratio of 6:1 between high and low benefit states. Looking at combined AFDC and food stamps that ratio falls to 2:1 because food stamps helps fill in the gaps. With each state deciding how much nutrition support to provide and to whom, some states seem likely to select significantly lower nutrition support than is offered now. It seems especially unlikely that states like Mississippi would choose to spend *more* on nutrition per poor family than would states like Connecticut when the former state has half the per capita income and three times the poverty rate of the latter. With a swap there is a danger of serious hunger returning to the U.S. in some states. And without the equalizing role of food stamps, disparities in support between states are likely to grow.

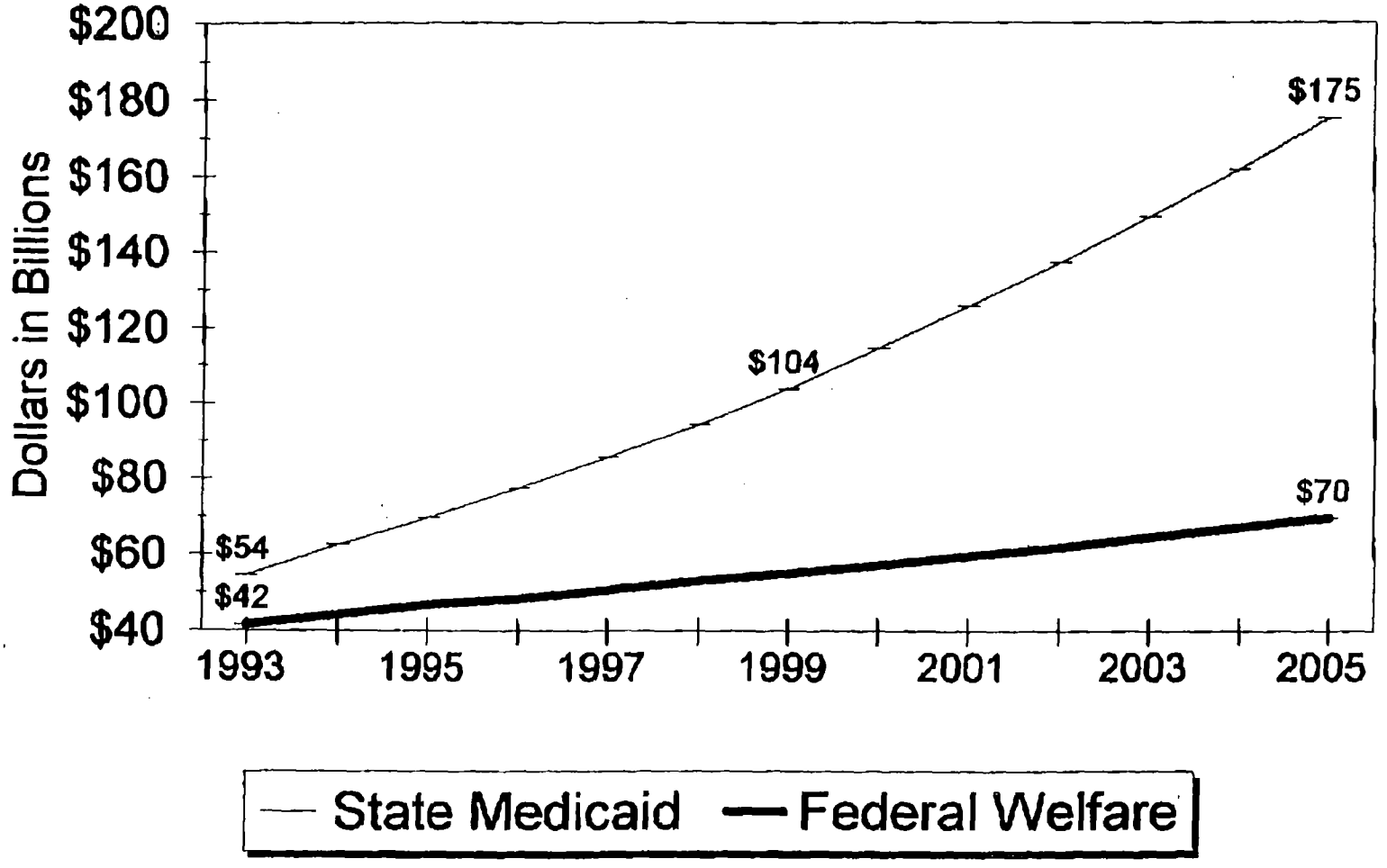
Equally importantly, during state recessions, food stamps automatically rise as more people lose their jobs and fall into poverty. Since food stamps is 100% federal and AFDC is 50-80% federal, these programs serve as automatic economic stabilizers, putting additional federal support into places where times are bad. Without this automatic adjustment, states entering recessions would be faced with a double hit: both decreased revenues and increased numbers of persons on the state's poverty programs.

Expenditures For the Swap: 1996



Federal Welfare & State Medicaid

Comparision of Expenditure Trends



Net Effects of Swap Options on the Deficit

(Fiscal Years, Dollars in Billions)

SWAP FEDERAL AFDC, FOOD STAMPS & WIC FOR:	1996 - 2000	1996 - 2005
All State Medicaid Services for All Current Recipients	$213	$640
All State Medicaid Services for Aged and Disabled	$29	$176
State Medicaid Acute Care Services Only for All Current Recipients	$7	$127
State Medicaid Acute Care Services Only for AFDC and Non-Cash Kids Only	($143)	($278)

Increases in the Deficit indicated by positive numbers. Decreases in the Deficit indicated by negative numbers.

Estimated State Fiscal Effects of Medicaid for AFDC/Food Stamps/WIC Swap

(state fiscal effects in millions)

State	Fiscal Year 1996			Fiscal Year 2002		
	Projected State Costs on Acute Care Medicaid	Projected Federal Costs AFDC + FNS	State Gain (Loss)	Projected State Costs on Acute Care Medicaid	Projected Federal Costs AFDC + FNS	State Gain (Loss)
California	$6,941	$6,882	$59	$12,979	$8,838	$4,141
Connecticut	$446	$478	($32)	$835	$614	$221
Indiana	$742	$778	($36)	$1,388	$999	$389
Michigan	$1,584	$2,086	($502)	$2,962	$2,679	$283
Mississippi	$219	$647	($428)	$410	$831	($421)
Texas	$2,048	$3,540	($1,492)	$3,830	$4,546	($716)
U.S. Total	**$43,150**	**$48,297**	**($5,147)**	**$80,700**	**$62,022**	**$18,678**

* Medicaid estimates for 1996 were calculated by HCFA; estimates for 2002 assume the national growth rate for acute care services.

** Food & Nutrition Services program estimates past 2000 were calculated by ASPE staff.

BENEFIT VARIATION ACROSS PROGRAMS

AFDC and Food Stamp Monthly Benefits
For a one-parent family of three persons, July 1994

State	AFDC Benefit Only	Food Stamp Benefit Only	AFDC & Food Stamps Combined (State Contribution)	% of Total Benefit Provided By State
Mississippi	$120	$295	415 (25)	6%
Texas	$188	$295	483 (67)	14%
Indiana	$288	$278	566 (105)	19%
Michigan	$459	$227	686 (200)	29%
California	$607	$183	790 (304)	38%
Connecticut	$680	$161	841 (340)	40%

- AFDC is a program where federal share varies from 50% to 80%
- Food Stamps is a program with 100% federal share (except administrative costs).

DEPARTMENT OF THE TREASURY
OFFICE OF TAX POLICY
1500 PENNSYLVANIA AVENUE, NW
WASHINGTON, DC 20220

Date: December 22, 1994

Number of Pages to Follow: Five (5)

To: Kim O'Neill

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Addressee's Confirmation Number: 456-5587

From: Eric J. Toder
Deputy Assistant Secretary (Tax Analysis)

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Comments/Special Instructions:

UNCLASSIFIED

DEPARTMENT OF THE TREASURY
WASHINGTON

December 22, 1994

MEMORANDUM FOR ROBERT RUBIN
ASSISTANT TO THE PRESIDENT FOR ECONOMIC POLICY

FROM: ERIC TODER
DEPUTY ASSISTANT SECRETARY (TAX ANALYSIS)

SUBJECT: Briefing Papers on Tax Cap and Medical Savings Accounts Proposals

In response to your request, I have prepared briefing papers for the President on tax cap and medical savings accounts proposals. The briefing papers contain a summary of the conclusions reached at the NEC meeting on cost containment in November. In addition, the papers provide background on the types of proposals which have been considered by the Administration and Congress during the past year.

Attachments

Tax Caps on Employer Contributions for Health Insurance

NEC Conclusions:

- Limiting the tax preference for employer-provided health insurance could dampen the demand for health insurance, thereby restraining the growth in health expenditures to some degree.

- Tax cap proposals will also raise revenues and can serve as an offset to other budgetary costs associated with a health reform proposal.

- Depending on its design, a tax cap may be difficult to administer or inequitable in its impact among employees, particularly in the absence of a comprehensive health reform package.

- Tax cap proposals will face significant political hurdles, including strong opposition from organized labor and the business community. A tax cap proposal could be viewed as a middle class tax increase.

Background:

- The tax code provides preferential treatment for employer contributions for health insurance benefits.

  -- Taxpayers do not include employer contributions for accident or health insurance in their gross income or social security earnings.

  -- Business expenses are deducted from employers' gross income. Wages, salaries, and fringe benefits (including health insurance) are allowable business expenses.

- By reducing the costs of health insurance, the tax code encourages individuals to obtain more health insurance coverage. However, these preferences also create an incentive to purchase more comprehensive coverage than workers might actually require.

- Tax caps would increase consumers' awareness of the costs of medical care. CBO estimates that an aggressive tax cap, which limited tax-free contributions to the lowest cost plan in a region, could reduce national health expenditures by about 1 percent if combined with other aspects of managed competition.

- Revenues from a tax cap may be used to finance other aspects of a health reform plan or for deficit reduction. However, the revenues from a tax cap are very dependent on other aspects of a health reform plan.

- Under the Health Security Act, employer contributions for supplemental policies for benefits which were not covered under the comprehensive benefit package would be includable in gross income and social security earnings. The tax cap was effective in 2004.

- Consumer cost consciousness would be enhanced if employer contributions for supplemental policies that cover copayments, deductibles, and coinsurance were also subject to income and social security taxes.

- The tax cap proposal in HSA was a "design-based" cap; that is, the tax preference was limited to plans offering a specified set of benefits. Some tax cap proposals limit the tax preference to plans costing a specified amount ("dollar-based" cap).

- A dollar-based tax cap treats some workers inequitably. For example, older workers, with higher health insurance premiums, would be more likely to be subject to a dollar-based tax cap than a younger workforce. A design-based cap would generally be more equitable.

- A dollar-based cap is often viewed as easier to administer than a design-based cap because the IRS and employers would not be required to value each taxpayer's health insurance plan. But even a dollar-based cap would be difficult to administer, if the dollar threshold varied to reflect age and regional cost differences. A design-based tax cap would be easier to administer, but only if a health reform plan also includes a standard benefit package.

- Under HSA, the tax cap applied to the employee's exclusion of employer contributions for health insurance. Alternatively, a tax cap could be applied by limiting the employers' deduction for health insurance. Under this approach, employers with no tax liability (e.g., a government entity or a tax-exempt organization) would be exempt from the tax cap. A better way to collect the tax would be to apply an excise tax on health insurance contributions to all employers, regardless of whether they have taxable income or not.

Medical Savings Accounts

NEC Conclusions:

- Medical Savings Accounts (MSAs) are politically appealing.
- MSAs may have an adverse effect on the health insurance market. As a result, premiums of the less healthy would rise, while premiums of the healthy would fall.
- MSAs would probably not produce much cost containment.

Background:

- Health reform proposals by Dole, Chafee, Michel, Santorum, and Gephardt include variants of Medical Savings Accounts (MSAs). The Bush Administration worked with several members of Congress towards developing an MSA proposal. Many Republicans and some Democrats favor MSAs. The Health Security Act did not include MSAs, but the proposal approved by the Ways and Means Committee did.
- MSA proposals allow taxpayers to place funds in a special tax-preferred account. Funds from MSAs that are used for specified medical purposes are not taxed, while funds used for other purposes may or may not be taxed depending upon the proposal.
- The intent of an MSA is to encourage employers and employees to switch from "comprehensive" health insurance to "catastrophic" packages that have higher co-payments and deductibles, thereby giving employees an incentive to reduce unnecessary medical care.
- In general, MSAs could provide a mechanism for tax-preferred saving for healthy individuals while causing premiums for less healthy individuals to rise. Adverse selection may result in healthy and upper income individuals joining MSAs, leaving less healthy and lower income individuals in the more comprehensive Fee-For-Service plans and HMO plans. As a result, premiums of the less healthy would rise, while premiums of the healthy would fall. This kind of reform would undermine community-rating. Risk-adjusters and taxes could be devised to reduce these effects. However, risk adjusters are imprecise; would be difficult to do correctly; and would be viewed as administratively burdensome.

- MSAs would reduce insurance premiums for participants but expose them to larger out-of-pocket costs. Some individuals who unexpectedly become sick may find themselves short of funds to cover their medical expenses.

- A Rand study of health insurance, conducted in the 1970's, suggests that if an individual switches from a plan with a $200 deductible to a plan with a $2,000 deductible that individual would reduce total health expenditures by 10 percent. Ten percent is an upper bound. Because there would be no savings for nonparticipants and for those who switch from cost effective HMOs to MSAs, aggregate savings would probably be much lower than 10 percent, depending upon participation. (Some people outside the Administration may believe that cost savings are greater than 10 percent, but some participants in the NEC meeting believe savings are close to zero.)

- Greater participation in catastrophic plans would reduce costs somewhat. However there are better ways to encourage the use of catastrophic plans. These include: (1) tax caps on co-payments and deductibles; or (2) expanded deductibility of medical expenses. Other health insurance market reforms might also be designed to encourage catastrophic plans or cost containment. However, cost containment will still be difficult to obtain.

- If MSA proposals go forward, they should be carefully designed to reduce adverse effects. Different MSA designs lead to different magnitudes of effects. Design features to be considered include: (1) limits on contributions; (2) tax treatment of earnings in the funds; (3) limits on and tax treatment of withdrawals for nonmedical purposes; and (4) tightening the definition of medical withdrawals. The limits and other design features should depend to some extent on other MSA design features such as risk adjustors.