



**AN ANALYSIS OF THE  
ADMINISTRATION'S HEALTH PROPOSAL**

**The Congress of the United States  
Congressional Budget Office**

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## NOTES

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

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

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# Preface

**T**he Congressional Budget Office (CBO) has prepared this analysis of the Administration's health proposal in response to several Congressional requests. The report contains an overview of the Administration's proposal and an estimate of its effects on national health expenditures and the federal budget. The report also examines the budgetary treatment of the proposal, its impact on the economy, and other considerations affecting the proposal's implementation.

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

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

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# Summary

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

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

To strengthen the demand side of the health care marketplace, the proposal would establish regional purchasing alliances through which most people who worked for firms with 5,000 or fewer full-time employees would obtain health coverage, as would most other people under age 65 who had no connection to the labor force. Larger firms, firms participating in multiemployer group plans, rural electric cooperatives and telephone cooperative associations, as well as the U.S. Postal Service, would be entitled to establish their own corporate

alliances. Medicare beneficiaries would generally remain outside the alliance system. States could choose to opt out of the regional alliance system entirely and establish a "single-payer" system of health care financing, in which the state would pay all providers directly.

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

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

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

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

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

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

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## Uncertainty of the Estimates

Estimates of the interactive effects of so many complex changes to an industry that encompasses one-seventh of the economy are highly uncertain. Assumptions, used by the Congressional Budget Office (CBO) and other analysts, about people's behavioral responses to new incentives are frequently based on

research evidence from small changes in the existing marketplace. In the case of the Administration's proposal, however, the entire marketplace and the configurations of the actors within it would be changing, and there is no precedent for estimating the effects on health spending or the economy.

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

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## Financial Impact of the Proposal

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

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

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

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

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

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## Effects on the Economy

Although the Administration's proposal would make fundamental changes in the current health care system, the overall economic impact of those changes might not be large. Because the proposal would involve substantial redistributions within the

economy, however, the impact on business costs and employment might be significant for individual firms and people. Similarly, though the proposal would have little predictable effect on national saving and investment, or on the balance of trade, some businesses could see their ability to compete with foreign firms either improving or worsening.

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

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

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

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

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

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

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

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

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

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

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

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## Budgetary Treatment of the Proposal

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

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

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

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

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## Conclusion

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

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

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

