Chapter Two

Financial Impact of the Proposal

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

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

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

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

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

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

How the Proposal Affects National Health Expenditures

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

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

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

SOURCE: Congressional Budget Office.

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

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

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

How the Proposal Affects On-Budget Programs and Social Security

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

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

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

Health Insurance Premiums

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

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

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

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

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

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

Table 2-2.
Continued

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

SOURCES: Congressional Budget Office; Joint Committee on Taxation.

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

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

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

a. Less than $500 million.

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

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

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

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

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

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

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

Corporate Alliances

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

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

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

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

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

Subsidies for Employers

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

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

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

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

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

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

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

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

Subsidies for Families

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

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

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

Total Federal Subsidies

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

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

Changes in Medicare

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

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

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

SOURCE: Congressional Budget Office.

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

a. Less than $500 million.

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

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

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

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

Changes in Medicaid

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

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

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

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

Long-Term Care Benefit

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

Changes in Other Federal Programs

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

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

Changes in Revenues

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

How CBO's Estimates Compare with Those of the Administration

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

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

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

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

a. Less than $500 million.

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

Subsidies for Employers

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

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

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

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

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

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

Other Differences

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

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

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

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

Sensitivity of the Estimates to Premium Levels

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

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

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

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

SOURCE: Congressional Budget Office.

a. Less than $500 million.

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

Sources and Uses of Funds of the Health Alliances

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