

CHAPTER II

DESCRIPTION OF THE HERITAGE AND

PAULY GROUP PROPOSALS

The Heritage and Pauly group proposals would both change the health insurance system profoundly. They would also have substantial impacts on the delivery of health care, but these impacts would be indirect and are not discussed at length by the proponents. The proposals have many similarities, though there are important areas of difference (see Table 1).

COMMON ELEMENTS

The proposals share three essential elements: a mandate on individuals to obtain health insurance, the replacement of current tax provisions that subsidize health spending with a single broad-based provision, and the introduction of a strong federal role in determining which pricing and marketing practices health insurers could and could not follow.

Mandate on Individuals

Under the provisions of both proposals, everyone would be required to obtain health insurance from either a public program or a private plan, in their own name or as another person's dependent. (The Pauly group proposal refers only to citizens, although the mandate presumably would apply to resident aliens as well. Neither proposal specifies whether the mandate would apply to citizens living abroad.) The Heritage Foundation lists the applicable public programs as Medicare, Medicaid, the military health services system (which covers active-duty personnel, military retirees, and dependents), the Department of Veterans Affairs' medical system, and the Indian Health Service. The Pauly group proposal does not list specific public programs other than Medicare.

Under the Heritage proposal, states would identify and arrange coverage for people who did not obtain coverage for themselves; states could charge these people premiums based on the cost of coverage and the individual's ability to pay. To assist the states, employers would be required to report workers who did not have proof of insurance.

TABLE 1. COMPARISON OF THE HERITAGE AND PAULY GROUP PROPOSALS WITH THE CURRENT HEALTH CARE SYSTEM

	Current Law	Heritage Proposal	Pauly Group Proposal
Individual Mandate	None.	Everyone must have at least minimum benefit plan. States responsible for identifying and arranging coverage for people without insurance.	Everyone must have at least minimum benefit plan. Mandate enforced through taxation and welfare systems; no specification of federal and state roles.
Minimum Benefit Plan	None.	"Catastrophic" coverage of medically necessary acute care services, with deductible of \$1,000 (individual) or \$2,000 (family) and stop-loss limit of \$5,000. No coinsurance rate specified.	Coverage of acute and preventive care; also, out-of-pocket expenses limited to a percentage of income. No further details provided.
Supplementary Insurance	Not applicable.	Anyone may buy insurance to supplement the minimum benefit plan; premiums receive the same tax treatment as premiums paid for the minimum benefit plan.	Anyone may buy insurance to supplement the minimum benefit plan; premiums receive the same tax treatment as premiums paid for the minimum benefit plan.
Tax Subsidies Related to Health	<ol style="list-style-type: none"> 1) Employer-paid benefits are excluded from employees' taxable income. 2) Employees in certain flexible benefit plans may use pretax income to pay premiums and out-of-pocket expenses. 3) Taxpayers may deduct health expenses over 7.5 percent of adjusted gross income. 	<ol style="list-style-type: none"> 1) Replaced with refundable tax credit, varying with income and health expenses (defined as the sum of premiums paid for minimum and supplementary plans and out-of-pocket health expenses). 2) Repealed. 3) Repealed. 	<ol style="list-style-type: none"> 1) Replaced with refundable tax credit, varying with family income, demographics, and health status. It would not vary with actual health expenses. 2) Repealed. 3) Repealed.

(Continued)

TABLE 1. CONTINUED

	Current Law	Heritage Proposal	Pauly Group Proposal
New Program	Not applicable.	Federal/state program for low-income people with high health expenses.	Not applicable.
Role of Medicare Program	Cover acute care for the elderly and certain people with disabilities.	Continue current program. Eventually, enrollees could receive vouchers with which to choose their own plan.	Continue current program. Eventually, the proposed system could replace Medicare.
Role of Medicaid Program	Cover acute and long-term care for certain groups of low-income people.	Continue current program. People who become ineligible for Medicaid buy insurance and receive tax credit.	Acute care benefits eliminated for people under age 65; Medicaid beneficiaries buy subsidized minimum benefit plan.
Regulatory Roles	States have strong roles; federal law regulates self-insured employers.	Federal government sets standards that states administer.	Federal law allows insurers broad latitude in setting premiums.
Insurance Regulation	Varies widely among the states; regulation of premiums is common, especially in the individual and small-group markets.	Premiums vary with age, sex, and geographic residence; discounts may reflect lower marketing costs to groups; guaranteed issue; guaranteed renewal.	Pure risk rating allowed for initial premiums; if impractical, replaced with limits on premiums. Insurers restricted in setting renewal premiums.
Role of Employers	At employer's option, arrange and pay for insurance.	At employer's option, pay for insurance. Report value of benefit to Internal Revenue Service in line with demographic categories. Must "cash out" current benefits to employees. Cannot require participation in own plan.	At employer's option, arrange and pay for insurance. Report value of benefit to Internal Revenue Service; can choose valuation method itself. Need not allow employees to "cash out" current benefits. May require participation in own plan.

(Continued)

TABLE 1. CONTINUED

	Current Law	Heritage Proposal	Pauly Group Proposal
Positive Impacts on the Federal Budget (Relative to Current Law)	Not applicable.	Elimination of tax exclusion, health-related flexible benefit plans, and deductibility of health expenses; cap on federal Medicaid payments; elimination of Medicare and Medicaid payments to disproportionate share hospitals; certain Medicare changes.	Elimination of tax exclusion, health-related flexible benefit plans, and deductibility of health expenses; reduction in payments for Medicaid acute care services.
Negative Impacts on the Federal Budget	Not applicable.	Tax credit; new federal/state program; possible increase in popularity of non-health fringe benefits.	Tax credit; increased popularity of non-health fringe benefits.
Positive Impacts on State Budgets	Not applicable.	Possible increase in tax revenue; elimination of payments to disproportionate share hospitals; possible drop in uncompensated care.	Possible increase in tax revenue; reduction in payments for Medicaid acute care services; possible drop in uncompensated care.
Negative Impacts on State Budgets	Not applicable.	Arranging coverage for uninsured people; responsibility for paying Medicaid costs that exceed federal cap; contributions to new federal/state program.	Possibility of (unspecified) requirements by federal government to maintain current funding effort.

SOURCE: Congressional Budget Office.

The Pauly group proposal does not specify the responsibilities of the various levels of government, saying only that the mandate would be enforced through the taxation and welfare systems, which include a wide range of programs administered by all levels of government. People who did not choose an insurance plan themselves would be assigned to a "fallback" insurer, which would be a private-sector insurer that agreed to accept all applicants and to charge them premiums that depended on unspecified risk characteristics. A government agency would select the fallback insurer through a bidding process. Employees who did not demonstrate proof of coverage to their employer would be assigned to the fallback insurer and have premiums withheld from their paychecks. Similarly, uninsured people who receive checks from government programs such as welfare and unemployment assistance would have premiums withheld from those checks. The proposal does not include a way to enforce the mandate for people who do not have income from a job or from a government program. Although the proponents believe this group would be a negligible fraction of the population, there could be those who would avoid receiving such income if it meant that they became liable for the premiums.

Under either proposal, the federal government would determine the contents of the minimum benefit plan that people would need to meet the mandate. The comprehensiveness of the plan would be the single greatest determinant of its cost, which in turn would affect the affordability of the mandate for families and the impact on government finances. Under either proposal, anyone could also buy insurance to supplement the minimum plan. Premiums paid for supplementary coverage would receive the same tax treatment as premiums paid for the minimum plan.

Under the Heritage proposal, the minimum benefit plan would provide only "catastrophic" coverage; that is, it would protect policyholders only against the cost of large medical expenses. Under current law, a family with a typical employment-based plan might be responsible for the first \$400 of medical expenses a year, an amount known as the deductible. Once the deductible had been reached, the family might pay coinsurance equal to 20 percent of its additional expenses for covered services. Its maximum liability, or stop-loss limit, for both the deductible and coinsurance might be \$1,000 to \$2,000. The Heritage proposal, by contrast, calls for a deductible of \$1,000 for an individual and \$2,000 for a family, with a stop-loss limit of \$5,000 in either case. No coinsurance level is specified; as a result, insurers marketing to policyholders who were willing to accept higher risk in return for lower premiums could use coinsurance rates higher than the 20 percent rate common today. In the extreme case, a coinsurance rate of 99 percent would make the deductible equal to \$5,000 for all practical purposes. For the purposes of the illustrative calculations in this memorandum, the Congres-

sional Budget Office (CBO) has assumed that the typical policy would include a coinsurance rate of 20 percent.

Under the Heritage proposal, the minimum benefit plan would have to cover all acute care services that were medically necessary, including physicians' services, hospital care, unspecified "appropriate alternatives" to hospitalization, and prescription drugs. Services that would not have to be covered would include long-term, dental, and vision care; over-the-counter medications; cosmetic surgery; and mental health services, including care for serious mental illness. Based on these specifications, the Actuarial Research Corporation has estimated that the average premium to provide family coverage through such a plan would have been \$3,250 in 1991.

The Pauly group does not specify the contents of its proposed minimum benefit plan. At one point it refers to catastrophic coverage, but it then suggests that a starting point for defining the minimum plan could be "the services covered by a low-cost managed-care plan that has achieved a significant market share," which would imply more generous coverage.¹ In any case, the proposal calls for the minimum plan to have lower stop-loss limits for lower-income people, the reasoning being that lower-income people are less able to afford high deductibles and coinsurance payments. This provision would mean that lower-income people would pay greater premiums than higher-income people, other factors being equal. For purposes of comparing the Heritage and Pauly group proposals in this memorandum, CBO has assumed that the minimum benefits plan under the Pauly group proposal would be similar to that proposed by the Heritage Foundation.

Change in Tax Subsidies

Under current law, the principal tax subsidy for health-related expenses goes to people whose employers contribute to their insurance plans. Other health-related subsidies are available to people whose employers contribute to flexible benefit plans and to taxpayers whose medical expenses exceed 7.5 percent of adjusted gross income. Both proposals would replace these subsidies with a subsidy that would depend neither on employment nor on whether a person paid taxes.

Section 106 of the Internal Revenue Code states that employers' contributions to their employees' health insurance premiums are excluded

1. Mark Pauly and others, *Responsible National Health Insurance* (Washington, D.C.: AEI Press, 1992), p. 13.

from the calculation of employees' taxable income.² In 1991, employers spent \$192 billion on health insurance, and the value of the tax subsidy was estimated at \$46 billion in forgone revenue from income and payroll taxes.³ Eliminating the tax exclusion would substantially increase the proportion of employees' total compensation that is subject to taxation. It would also make retirees liable for taxes on health insurance premiums paid by their former employers.

Both proposals call for a refundable tax credit to subsidize spending on health care and insurance.⁴ The structures of the proposed credits differ, but in both cases the credit is designed to give greater subsidies to lower-income people and to those likely to incur higher expenses for health care and insurance. Unlike the tax exclusion, which subsidizes spending on insurance premiums but not on health care itself, the proposed credits would treat spending on insurance and out-of-pocket care similarly.

So that individuals would not have to wait until they filed their tax returns to receive the subsidy, employees would estimate their expected credit in the same way they now estimate the number of exemptions they will claim. The self-employed would do likewise in computing their estimated tax payments to the Internal Revenue Service. If an individual became unemployed or otherwise underwent a sharp change in circumstances, insurers or health care providers could be required to wait for payment until the credit was processed.

2. The tax exclusion is analyzed at length in Congressional Budget Office, *The Tax Treatment of Employment-Based Health Insurance* (March 1994).

3. Employer spending estimate from Cathy A. Cowan and Patricia A. McDonnell, "Business, Households, and Governments: Health Spending, 1991," *Health Care Financing Review*, vol. 14, no. 3 (Spring 1993), p. 228. Tax exclusion estimate from Executive Office of the President, *Budget of the United States Government: Fiscal Year 1993* (1992), part 2, p. 27.

The value of the tax exclusion in fiscal year 1995 is estimated at about \$90 billion. See Congressional Budget Office, *Reducing the Deficit: Spending and Revenue Options* (March 1994), p. 311.

4. A tax deduction reduces a person's taxable income, thus reducing his or her tax liability by an amount that depends on the person's marginal tax rate and that is therefore smaller than the size of the deduction. A tax credit reduces tax liability on a dollar-for-dollar basis. A refundable tax credit means that the government refunds money to the individual if the tax credit exceeds the tax liability. For taxation purposes, "total income" is the sum of wages, salaries, taxable interest income, capital gains, alimony received, and similar items. "Adjusted gross income" is total income minus contributions to individual retirement accounts, alimony payments, contributions to Keogh plans, and similar items. "Taxable income" is adjusted gross income minus deductions and the value of exemptions.

The proposals would also repeal two other provisions of current law. Under Section 125 of the tax code, employees enrolled in certain types of flexible benefit plans may use pretax income to pay for premiums, deductibles, coinsurance payments, and other out-of-pocket expenses, although if money set aside in such a plan is not used within a calendar year it is forfeited. Under Section 213, taxpayers whose health expenses exceed 7.5 percent of adjusted gross income may deduct the excess in calculating taxable income.⁵

Change in Federal and State Roles

Both proposals would set nationwide standards for the pricing and marketing of health insurance, an area of regulation that traditionally has been the domain of state governments. Both proposals would also make major changes in the way that the two levels of government share the cost of health programs.

Under current law, the states generally regulate the business of health insurance, which includes regulation of commercial insurers, Blue Cross and Blue Shield plans, and other risk-bearing entities such as health maintenance organizations. State regulation includes limiting the extent to which insurers may charge different policyholders different premiums; requiring insurers to deal with any willing provider; levying taxes on revenue from premiums; setting financial standards to ensure solvency; and mandating insurers to cover specific medical conditions, services, types of people, or types of providers.

In recent years, state legislatures have been very active in defining allowable pricing and marketing practices, particularly for insurance sold to small groups, which typically include 25 to 50 employees, depending on the state. By the end of 1993, 42 states had enacted laws circumscribing insurers' ability to set premiums for small groups.⁶ Although a comparable figure is not readily available, insurers traditionally have also been limited in the premiums they could charge for policies bought by individuals. Only in the large-group market are insurers relatively free to set premiums as they see fit.

5. Two other subsidies expired December 31, 1993. Under one provision, self-employed taxpayers were able to deduct 25 percent of the cost of health insurance; under the other, low-income people eligible for the earned income tax credit could claim a supplementary health insurance credit.

6. Intergovernmental Health Policy Project, The George Washington University, *Health Insurance: Small Groups: An Overview of 1993 State Legislative Activity* (Washington, D.C.: The George Washington University, 1993), pp. 3-6. See also Gretchen Babcock, Susan S. Laudicina, and Brice C. Oakley, *State Legislative Health Care and Insurance Issues* (Washington, D.C.: BlueCross BlueShield Association, December 1993), Appendix.

Employers that bear the financial risk for their employees' health care costs--a practice known as self-insurance--are exempt from state regulation under the federal Employee Retirement Income Security Act of 1974 (ERISA). Although ERISA includes provisions regulating employer health plans, these provisions are generally much less restrictive than state regulation.⁷ For example, self-insured firms need not cover specific benefits and need not pay state taxes on premiums.

Under the Heritage proposal, the federal government would set standards for the health insurance industry, particularly with regard to the pricing and marketing of the minimum benefit plan. While states would determine which plans met the federal standards, the federal government could take over that role from states that did not meet their responsibilities. Moreover, state laws would be preempted if they required insurers to cover specific diseases, services, or providers; if they restricted the ability of managed care plans to contract with some providers but not others; or if they restricted insurers' ability to require policyholders to share the cost of their care. Self-insured employers would be subject to the same rules as insurers generally, thus ending their special status under ERISA.

The Pauly group proposal would allow insurers complete freedom from regulation in setting premium rates for new policyholders but would restrict the premiums that they could charge policyholders renewing their coverage. Given the extensive regulation now in place in many states, federal law would have to preempt state laws specifically so that the Pauly group proposal could be put into effect. The proposal also calls for the federal government to preempt all state laws that mandate coverage of specific diseases, services, or providers; as in the Heritage proposal, this preemption would apply to both the minimum benefits and the supplementary plans. Laws that limited the ability of managed care plans to contract with some providers but not others would also be preempted. Self-insured employers would be subject to the same rules regarding solvency and similar matters as insurers are generally.

Proponents of both proposals anticipate that their plans would bring financial benefits to state and local governments. Under either proposal, state and local governments with tax regimes similar to federal law could experience increases in income tax revenues from the elimination of the current tax subsidies. They would also save money if the proposals reduced the amount of uncompensated care that these governments had to pay for.

7. For a fuller description of the state and federal roles, see Edward F. Shay, "Regulation of Employment-Based Health Benefits: The Intersection of State and Federal Law," in Institute of Medicine, *Employment and Health Benefits: A Connection at Risk* (Washington, D.C.: National Academy Press, 1993).

The Pauly group proposal would also reduce state spending under the Medicaid program, as discussed on page 22.

The Heritage proposal would impose responsibilities on states that would offset at least some of these financial benefits. The federal government's payments for Medicaid acute care services would be capped on a state-by-state basis, so that any state that exceeded its cap would pay the entire excess amount from its own budget. The general approach would be that in fiscal year 1995 each state would be allowed to spend 20 percent more than it did in fiscal year 1993, with increases thereafter allowed at somewhat more than the general inflation rate. Medicaid spending on long-term care would not be affected. Under current law, the federal government shares the cost of each state's Medicaid program in an open-ended fashion. In fiscal year 1991, the federal government spent \$52 billion on Medicaid and the states spent \$43 billion. Roughly 60 percent of the total was spent on acute care services; a precise breakdown as defined in the Heritage proposal is not readily available and would be subject to data limitations in any case.

The states would also be responsible for identifying uninsured people and arranging coverage for them, either through a state program or through private insurance. States would have to absorb the difference between the cost of coverage and any premiums they were able to collect. States that did not fulfill this role could lose all federal funding for health programs; the proposal does not include intermediate sanctions.

The Heritage Foundation also proposes a new system of federal block grants that the states would use primarily to assist people with incomes below 150 percent of the poverty threshold who were ineligible for Medicaid and whose health expenses exceeded 5 percent of adjusted gross income even after the tax credit was taken into account.⁸ States would have wide latitude in providing this aid and could also use the money for preventive and primary care services, to improve emergency medical services systems, and for similarly general purposes. The federal contribution to this new program would be \$14.2 billion in fiscal year 1997. This amount equals the Heritage Foundation's estimate of what federal payments would have been to hospitals defined to serve a "disproportionate number of low income patients with special needs"; disproportionate share hospital (DSH) payments under current Medicaid law would be discontinued. Similarly, states would be required to spend about as much on the new program as they otherwise would have spent on DSH payments. In fiscal year 1991, DSH payments were about \$9 billion,

8. The poverty threshold varies with family size. For a three-person family, it was \$10,860 in 1991, the year used for the numerical illustrations in this memorandum. For this family, income equal to 150 percent of the poverty threshold would be \$16,290.

although this number is a rough estimate since specific data on these payments were not collected in that year. In fiscal year 1992, when such data were collected, DSH payments were \$17 billion.

The Pauly group says that states could be required to spend as much on health programs as they would have spent under current law, or they could gradually be relieved of such a requirement, or they could be required to contribute an equal portion of income. "Congress's response to these options and the extent to which it requires states to contribute to the health care of their citizens depend upon broader issues of federalism and political balance," the Pauly group states.⁹

Both proposals would leave Medicare enrollees outside the system of tax credits, at least initially. The Heritage proposal notes that the Medicare population could be phased into the system of tax subsidies, possibly by providing enrollees with vouchers they could use to buy a plan. The Pauly group does not refer to vouchers. Instead, it suggests that after some point Medicare would no longer accept new enrollees but it would continue to provide coverage for people already enrolled. As part of funding its proposal, the Heritage Foundation would impose copayments on users of certain Medicare services and make other changes designed to reduce Medicare spending below what it would have been under current law. Analysis of the specific changes is beyond the scope of this memorandum.

DIFFERENCES BETWEEN THE PROPOSALS

The chief differences concern the structure of the proposed tax credit, the specific restrictions that would or would not be placed on insurers' pricing and marketing practices, the role of employers, and the role of the Medicaid program. As noted in the previous subsection, there are also less important differences concerning such features as enforcement of the mandate that individuals have insurance coverage.

Structure of the Tax Credit

The Heritage Foundation's proposed credit would vary with a family's health expenses, while the Pauly group's proposed credit would not. The Pauly group therefore calls its proposed credit a "fixed dollar" credit, although it would be different for different people.

9. Pauly and others, *Responsible National Health Insurance*, p. 26.

Under the Heritage proposal, the credit would be available to everyone who bought the minimum benefit plan; it would not be available to people covered by Medicare, Medicaid, the military health services system, the Department of Veterans Affairs' medical system, or the Indian Health Service. (The proposal does not say whether people eligible for, say, military health care could choose to forgo that coverage in favor of buying private insurance and receiving the tax credit.) People who had the minimum plan only part of the year (perhaps because they had previously been covered by a public program) would have their credit prorated by the number of entire months in which they had the minimum plan.

A very large part of health spending would be eligible for the credit. "Health expenses" would be defined as the sum of premiums for the minimum benefit plan, premiums for supplementary plans, and eligible out-of-pocket medical expenses. Supplementary plans could provide more generous coverage of services included in the minimum plan or could cover supplementary services such as dental care, vision care, or mental health services, but not long-term care. Eligible out-of-pocket expenses would include deductibles and coinsurance payments as well as out-of-pocket spending on a broad range of health care services, including related transportation services. Over-the-counter medications, long-term care, and cosmetic surgery would be specifically excluded.

The credit would equal 25 percent of that portion of health expenses up to 10 percent of adjusted gross income, plus 50 percent of that portion of expenses between 10 percent and 20 percent of AGI, plus 75 percent of that portion of expenses over 20 percent of AGI. For example, a family with AGI of \$30,000 that spent \$5,000 for the minimum benefit plan, \$700 for a supplementary plan, and \$500 in eligible out-of-pocket expenses would receive a credit of \$2,400 on its total spending of \$6,200.

Taxpayers could also claim a 25 percent nonrefundable credit for contributions to medical savings accounts. An individual could make annual contributions up to \$3,000, plus \$500 per dependent, to such an account, withdrawing the money in later years to pay health bills. Medical savings accounts are not an essential part of the Heritage proposal, and an analysis of their features and possible effects is beyond the scope of this memorandum.

The Pauly group proposal does not specify who would and would not be eligible for the tax credit, except that Medicare enrollees would be ineligible. A family would receive a credit that would be correlated to its likely use of health care, not its actual use. Unlike the Heritage proposal, there would be no need to define a list of expenses that would count toward the credit.

Calculating the credit for a particular family would be composed of two steps. The base value of the credit would equal the lowest bid made by an insurer for the position of fallback insurer--that is, for the role of covering people who did not choose an insurer. If, for example, the fallback insurer charged \$3,000 to provide coverage for a family of average risk, the basic credit would be \$3,000. Families of average risk below the poverty threshold would receive \$3,000, and the subsidy would decline as income rose until it reached zero at three to five times the threshold. For a particular family, the base value of the credit would then be adjusted to reflect the age, sex, geographic residence, and health status of family members, since these factors are generally correlated with spending on health care.

The proposal does not specify how the adjustments would be made; health status, in particular, can be difficult to quantify and verify. For example, while some insurers might use blood tests and other diagnostic tools to set premiums, it is unlikely that the Internal Revenue Service would collect such information. Therefore, the practicality of the adjustment process cannot be predicted.

The Pauly group also raises the possibility of a supplemental credit available to families whose premiums are more than 50 percent higher than the average for families of the same demographic characteristics. This supplemental credit would be a percentage of the adjusted credit. The group does not elaborate on this suggestion.

Regulation of Pricing and Marketing of Insurance

Under the Heritage proposal, insurers would face tight restrictions on the pricing and marketing of the minimum benefits plan. Under the Pauly group proposal, by contrast, insurers would be allowed broad scope to set premiums and market their plans, at least initially.

Under the Heritage proposal, each insurer would set its own premium schedule for individual and family policies, but premiums could vary only with the age, sex, and geographic residence of the policyholder. Each insurer would have to charge all of its policyholders who have specified demographic characteristics the same premium, regardless of whether they were new or existing policyholders. An important exception is that members of a group could be given discounts to reflect lower marketing and administrative costs. Insurers could also offer discounts designed to promote health, prevent illness, or allow the early detection of illness.

The Heritage proposal would require insurers to accept all applicants and to renew all policies, except in cases of fraud, misrepresentation, or non-payment of premiums. In the year after the proposal would be put in place, no limitations could be placed on coverage of preexisting medical conditions; this provision would encourage people who are now uninsured to seek coverage. After the first year, coverage could be limited for up to one year if the person previously had been uninsured. The states would administer these regulations; for example, they would define the demographic categories that insurers would use and would say what discounts for group purchasing would be allowable.

Under the Pauly group proposal, insurers would be free to set any premiums they wished for new policyholders, at least initially. As a consequence, the proposal anticipates that insurers would make more use of risk rating, in which higher-risk people pay greater premiums than lower-risk people. Aside from age, sex, and geographic residence, insurers could use health status, occupation, or any other factor in evaluating the risk of applicants. The reasoning, the Pauly group states, is that with full risk rating, "insurers have no reason to reject high risks if they can charge an adequate rate and have no incentive to market aggressively to low risks if rates for low risks are bid down to competitive levels."¹⁰ Preexisting medical conditions would have to be covered, but the insurer could charge the corresponding premium.

Although insurers would be free from regulation in setting premiums for new policyholders, they would be restricted in setting premiums for policyholders who renew their coverage. If a policyholder's risk of using health care rose (for example, due to a diagnosis of serious illness), the insurer would have to wait three years before it could increase the premium to reflect the higher risk level. In the interim, premium increases could only reflect broad increases in the cost of providing coverage. (The proposal does not specify how this requirement would be applied to group policies.) The Pauly group's reasoning for this provision is that policyholders should have some protection from being penalized when they become more likely to use insurance; the protection is not extended indefinitely on the grounds it would be infeasible.

Although the Pauly group would allow "full and free risk rating" as outlined above, the proposal also states that more restrictive rules could be put into effect if full risk rating proved impracticable. Restrictions to establish actuarial categories, as in the Heritage proposal, could be introduced

10. Pauly and others, "A Plan for 'Responsible National Health Insurance'," *Health Affairs*, vol. 10, no. 1 (Spring 1991), p. 15.

if it were true that "high risks still face unacceptably large differences in after-tax premium costs or that administration of risk-related tax credits is difficult."¹¹

The Employer Role

Although both proposals would impose some similar requirements on employers, the differences between the proposals are more significant than the similarities. Under both proposals, employers would have to report to the Internal Revenue Service the value of employer-paid premiums for each employee, but how to apportion a group premium to individual group members is not easy to determine. Employers now tend to pay a lump-sum premium to an insurer for an entire group; for example, a company might pay \$300,000 to cover 100 employees. The simplest method would be for an employer to apportion the premium equally. In that case, each employee would see a \$3,000 increase in taxable income. But an argument can be made that the value of health insurance varies widely among employees; a 60-year-old employee, for example, might have to pay three or four times as much as a 25-year-old if they each bought coverage on their own. Under those circumstances, it could be argued that employer-provided health insurance might be worth \$4,800 to the older employee and only \$1,200 to the younger employee. Other methods of apportionment are conceivable, such as increasing each employee's taxable income by the same percentage of cash income.

The Heritage proposal would require that the group premium be apportioned using the same categories that insurers would use to set individual premiums: that is, age, sex, and geographic residence. Moreover, employers would be required to pay these amounts in cash to their employees, who could choose to continue their workplace-based plan or to buy coverage elsewhere.

The Pauly group would let each employer decide how to apportion the group premium for tax purposes. Employers would not have to pay out the value of the premium in cash and would not have to give employees a choice of plans. Despite the lack of restrictions, employers would probably tend to apportion the group premium using the same adjustment factors that the government would use to allocate tax credits to individuals. Otherwise, some employees might complain of inequitable treatment. For example, if two employees earn the same salary, and one is in a low-risk category and the other in a high-risk category, and if the group premium were apportioned

11. Pauly and others, *Responsible National Health Insurance*, p. 42.

equally, both employees would see the same increase in tax liability (before the credit was calculated), but the low-risk employee would receive a smaller tax credit than the high-risk employee.

Both proposals would end the distinction between employers whose employees are covered by an insurer and employers that are self-insured. Under the Heritage proposal, self-insured employers would have to cash out their plans, allow their employees to go elsewhere for coverage, and accept applicants from outside at the same premium rates that would apply to employees. Ending the special status of self-insured employers would have fewer consequences under the Pauly group proposal, since that proposal would place fewer requirements on both insurers and employers.

Both proposals would make employers liable for the employer share of the payroll taxes that would be levied on employees' increased income. CBO has not estimated the size of this liability; a study done for the Heritage Foundation estimated it at \$7.8 billion in 1991, including the effect of corporate income taxes. Both proposals would try to ensure that employers paid this tax themselves rather than taking it from employees' wages and salaries, at least in the first year. In time, however, CBO would expect employers to reduce wage growth, so that eventually the "employer" share of the payroll tax would be borne by employees because wages would be lower than they would have been otherwise. Even in the transition year, it would be impossible to prevent employers from increasing wages by a smaller amount than they would have if they had not paid a payroll tax.

Both proposals would require employers to cooperate with the government in identifying people who had no insurance and in including the anticipated value of employees' tax credits in their paychecks. Under the Heritage proposal, which specifies that the credit would depend on a year's actual health expenses, estimating the value of the credit would be more difficult than under the Pauly group proposal, which specifies that it would not. Furthermore, the Heritage proposal would require all employers to deduct premiums from paychecks and to forward the premiums to insurers, regardless of whether employees were willing to handle this task themselves.

Medicaid

The Heritage proposal would not change the eligibility rules or benefits of the Medicaid program, while the Pauly group proposal would replace almost all of what are now Medicaid's acute care benefits.

Under the Heritage proposal, current Medicaid beneficiaries would continue to receive benefits from the program. When those people became ineligible for Medicaid, for whatever reason, they would have to buy private insurance and would become eligible for the refundable tax credit. Local welfare offices could verify their income and arrange for their anticipated tax credit to be advanced to them.

Under the Pauly group proposal, Medicaid would no longer cover acute care for beneficiaries under age 65, although it would still cover long-term care. Since only about half the people with income below the poverty threshold now receive Medicaid benefits, the proposal would approximately double the number of people in poverty who would have fully subsidized coverage.¹² The proposal does not offer any further detail on how the minimum benefit plan--which could be less comprehensive than current Medicaid coverage--would replace the program's acute care benefits, especially since these benefits vary considerably among the states. People with fully subsidized coverage would still be responsible for meeting the deductibles and coinsurance requirements of the minimum benefit plan, although their liability would be limited by the requirement that stop-loss limits be lower for lower-income people.

12. House Committee on Energy and Commerce, Subcommittee on Health and the Environment, *Medicaid Source Book: Background Data and Analysis (A 1993 Update)*, Committee Print 103-A (prepared by the Congressional Research Service, January 1993), p. 3.

