

## CHAPTER III

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### POTENTIAL IMPLICATIONS

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#### OF THE PROPOSALS

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Both the Heritage Foundation and Pauly group proposals would cause large-scale changes in the employment-based market for insurance, although the nature of these changes would differ markedly between the two proposals. The changes in the insurance market, combined with the proposed changes in tax law, would affect virtually every family in the country that is not covered by a government program. By changing people's incentives, the proposals would also affect national health care spending, although the net effect would be difficult to predict. Moreover, both proposals would have major implications for federal and state budgets.

### THE INSURANCE MARKET

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Both proposals would fundamentally change the workings of the insurance market, in very different ways. Before describing the possible implications, a sketch of the economics of health insurance may be helpful.

#### The Economics of Health Insurance

An insurer's basic goal is to operate so that revenues exceed costs. Costs include claims and administrative expenses. Claims, in turn, may be thought of as reflecting the insurer's efforts to select a risk portfolio and its efforts to manage the claims resulting from that portfolio.

Risk refers to the inherent likelihood that a person will incur health care costs. The wide range of risks among people can make it worthwhile for insurers to evaluate the riskiness of applicants as part of deciding whether to offer insurance and on what terms, a process described here as risk assessment. Applications from both individuals and groups may be assessed. Other factors being equal, women are more risky than men, older people are more risky than younger people, and people who live in some areas are more risky than those living in other areas. For example, a woman in the 55-64 age group living in an urban area can be expected to incur health care costs

almost four times as high as a man in the 25-34 age group in a rural area.<sup>1</sup> Other factors such as occupation and health status also help predict riskiness. The very fact that people seek insurance coverage can mean that they are unusually likely to use it, a pattern called adverse selection. A classic example is an uninsured couple who seek insurance when they intend to have a child.

Given its risk portfolio, an insurer has several means of controlling claims. These tools (and examples of them) include reducing the amounts paid to physicians and hospitals (by encouraging use of preferred providers); managing the use of care (by requiring approval before hospital admissions); encouraging healthful behavior (by providing discounts to nonsmokers); and adjusting the costs that policyholders pay (by increasing coinsurance rates).

Administrative expenses include the costs of risk assessment, claims processing, marketing, taxes, agents' commissions, and general overhead. These costs vary widely depending on the size of the insured group. In one study, they ranged from 5 percent of claims for groups of more than 10,000 employees to 40 percent for groups of fewer than five employees.<sup>2</sup>

On the revenue side, an insurer can set the degree to which premiums vary with the policyholder's risk of generating claims costs. Under pure community rating, all policyholders pay the same premium. Under pure risk rating, as would be allowed by the Pauly group, premiums vary widely to reflect each policyholder's anticipated cost to the insurer. (Since cost can be predicted only imperfectly, covered individuals still receive the benefits of insurance against unanticipated expenses.) Many rating systems lie between the extremes of pure community rating and pure risk rating. The Heritage proposal, for example, would allow insurers to adjust premiums to reflect some risk factors but not others.

Consider individuals whose risk levels differ. Under pure community rating, a 25-year-old healthy male would pay the same premium as a 60-year-old woman with diabetes. Under the Heritage proposal, the woman's age and sex would mean that she paid more than the man, but her premium would be no higher than that of another 60-year-old woman of average health. Under pure risk rating, the woman with diabetes would pay a higher premium than the other woman, and they both would pay higher premiums than the 25-year-

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1. This example reflects cost indexes calculated by the Actuarial Research Corporation and based on data from the 1987 National Medical Expenditure Survey.
  2. House Committee on Ways and Means, Subcommittee on Health, *Private Health Insurance: Options for Reform*, Committee Print 101-35 (prepared by the Congressional Research Service, September 1990), p. 12.

old man. The authors of both proposals point out that under pure community rating, lower-risk people subsidize higher-risk people regardless of their relative incomes, and that this cross-subsidy decreases as the method of setting premiums moves toward pure risk rating.

One method of risk rating is to take into account the policyholder's claims in the previous year. This method, known as experience rating, is commonly used in setting premiums for large employment-based groups. Regardless of whether risk rating takes the form of risk assessment on an individual basis in the individual and small-group markets or experience rating in the large-group market, the result for the insurer is that the policyholder pays a premium correlated with riskiness. For the consumer, the connection between individual riskiness and the premium paid is obvious in the individual market but becomes increasingly blurred as the size of the group increases.

Insurers' pricing and marketing practices both affect and are affected by the employment-based system that is prevalent today. According to analysis by the Congressional Budget Office of the March 1993 Current Population Survey, two-thirds of the population under the age of 65--or 146 million people--are insured through the workplace, either in their own name or as dependents. Another 17 percent of the under-65 population are uninsured, while 9 percent have Medicaid as their primary source of coverage, 7 percent pay for their own coverage, and 2 percent have Medicare as their primary coverage.

Employment-based insurance enjoys three advantages over the individual purchase of insurance. Perhaps the most important advantage is the exclusion of employer-paid premiums from employees' taxable incomes. Furthermore, marketing and similar overhead expenses tend to fall on a per-person basis as the size of the insured group increases. Third, as the size of an employment-based group increases, the group's past claims experience becomes an increasingly accurate predictor of its future claims, and the expense of assessing risks on an individual basis becomes less remunerative. Overall, insurers' concerns about adverse selection are allayed because individuals cannot easily become eligible for the group (they must be hired) and the coverage is financially attractive enough so that most people who are eligible to buy it do so.

### The Likely Impacts of the Proposals

The implications of the proposals for the insurance market would reflect the very different impacts they would have on employment-based insurance and on the determination of premiums. Under the Heritage proposal,

employment-based insurance as we know it today could end, since it would enjoy neither the tax advantages nor the degree of cost advantages that it does now. The ability of insurers to select risks and set premiums would be tightly regulated. Under the Pauly group proposal, employment-based insurance would be more likely to retain its current role, and insurers would have broad discretion to select risks and set premiums.

Although both proposals would repeal the tax exclusion, the Heritage proposal would also require an insurer to offer insurance to any applicant and to use a uniform premium schedule. Although groups based on employment (or any other affinity) could exist, the employer could not require workers to join the employer's plan and employees would pay their own premiums. Premiums charged to group members would have to be identical to those paid by other people covered by the same insurer, except that discounts would be allowed to reflect the lower marketing expenses of selling to a group. In practice, state regulation of these discounts would determine the extent to which similar individuals covered by the same insurer paid similar premiums. For example, if an insurer could offer different discounts to two demographically similar groups of the same size, it would be hard to argue that the insurer had a uniform premium schedule.

Self-insured employers would have to accept all applicants, even if they had no connection to the employer, and would do so using the same premium schedule that applied to employees. The self-insured employer would, in effect, be setting up an insurance subsidiary that competed with commercial insurers. Incentives to self-insure would be further reduced because employees would be responsible for paying premiums and because employers would no longer need to self-insure to avoid state laws mandating coverage of certain benefits. Under these circumstances, it is unlikely that many employers would continue to self-insure.

For consumers, the Heritage proposal would mean that the purchase of health insurance would become an individual decision in much the same way that the purchase of automobile insurance is. Since the link would be broken between health insurance and employment, health insurance would become portable between jobs in a way that is not true now.<sup>3</sup>

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3. Currently, people changing jobs may lose their coverage or have to pay higher premiums. In one 1991 survey, 13 percent of respondents said they or a family member had forgone a job opportunity solely because of health benefits; see Sarah Snider, "Public Opinion on Health, Retirement, and Other Employee Benefits," Issue Brief No. 132 (Employee Benefit Research Institute, Washington, D.C., December 1992), p. 7. In her paper "Employment-Based Health Insurance and Job Mobility: Is There Evidence of Job-Lock?" Working Paper No. 4476 (National Bureau of Economic Research, Cambridge, Mass., September 1993), Brigitte C. Madrian also finds evidence of decreased job mobility. For a contrary view, however, see Douglas Holtz-

For an insurer, the requirements to accept all applicants and to use a uniform premium schedule would greatly constrain its ability to select risks. But an insurer could still try to enroll low-risk policyholders (within a given demographic category) and discourage high-risk policyholders. For example, it could direct its marketing efforts at specific groups and not advertise its existence to the general public. It could also provide poor service to high-risk policyholders to encourage them to switch insurers or it could select a network of health care providers unlikely to attract high-cost patients. Perhaps most important, an insurer could design its supplementary benefit plan to appeal to lower-risk people, either with an explicit requirement that an applicant purchase both the minimum plan and the supplementary plan or on the assumption that many applicants would do so anyway. Although the proposal includes no provisions regulating supplementary insurance, states presumably would undertake this role to varying degrees.

Because the Heritage proposal would mean that insurers had less latitude to select their risk portfolios than is generally true now, insurers would place more emphasis on controlling the volume and the cost of the care that policyholders used. Consumers who found the restrictions too tight could take their business elsewhere, and the result would probably be a range of options that offered consumers varying trade-offs between premium levels, quality of care, and restrictions on use of care.

Under the Pauly group proposal, the insurance market would more closely resemble today's situation. An insurer would not have to use a uniform premium schedule and would not have to accept all applicants. Even though the tax exclusion would be repealed, an employment-based group would still offer administrative efficiencies and, perhaps more important, the employer could counter adverse selection by requiring employees to participate in its plan. These advantages would tend to increase as the size of the employment group increased.

Under this proposal, the total number of people who have employment-based insurance could fall or rise. Some people whose employers were willing to "cash out" their insurance plans would choose to buy coverage on their own or through such groups as religious organizations and professional associations. Nonetheless, approximately 37 million uninsured people--most of whom are employed or are dependents of employed people--would have to become insured, and some would do so through the workplace.

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Eakin, "Health Insurance Provision and Labor Market Efficiency in the United States and Germany," Working Paper No. 4388 (National Bureau of Economic Research, Cambridge, Mass., June 1993).

For many consumers, the Pauly group proposal would mean little change in their choice of insurance plans. If their employers continued to offer coverage, and in particular if the employer would only pay for its own plan, the consumer would probably continue his or her coverage uninterrupted. The only change would be that the value of the employer's contribution--however determined--would be included in the worker's taxable income.

For some employees, especially those who are older or sick, leaving a job could mean substantially higher premiums, much as is the case now. Other people could face higher premiums if they changed insurers soon after their health deteriorated. Everyone, however, would be assured that at least one insurer--the fallback insurer--would be willing to cover them, which is not true today.

Insurers would have strong incentives to use risk rating in the individual and small-group markets, since an insurer that did not do so would probably end up covering people who are relatively likely to make claims--that is, experiencing adverse selection. This would be more true than it is now, since putting the Pauly group proposal into effect would require federal preemption of the laws that now restrict rating practices. The impact on the large-group market--and where insurers would draw the line between small and large groups--is more difficult to predict. If, despite the elimination of the tax exclusion, the typical large employment-based group continued to constitute a relatively predictable risk portfolio, insurers would probably continue to use the experience-rating methods that are common today. In any case, insurers would be free to match premiums to policyholders' expected claims costs, leaving them with fewer incentives than they have today to engage in risk selection.

Either proposal could mean that the variability of premiums paid by consumers would increase; that is, premiums would reflect individual risk levels to a greater extent than they do now. Any change in the variability of premiums would have significant effects, since increased variability would increase the importance--and the difficulty--of matching subsidies to health expenses on a family-by-family basis.

In today's system the premiums paid by people in employment-based plans generally do not vary with individual risk level, and even some people

outside such groups are charged community rates.<sup>4</sup> Under the Heritage proposal, any insurer that did not set premiums that varied with age, sex, and geographic residence could expect to experience adverse selection. Two people in an employment-based group who now pay similar premiums could pay very different rates in the future, depending on their demographic characteristics. Conversely, two similar people, one who has employment-based insurance under current law and the other who buys insurance individually, would find that the Heritage proposal narrowed the disparity between the costs of their insurance.

Under the Pauly group proposal, preempting the laws that now limit the range of premiums in the individual and small-group markets would presumably increase the variability of premiums in those markets. There would also be a natural tendency for employers to report the value of health insurance to the Internal Revenue Service as different for different employees, to parallel the method the IRS would use to adjust the basic tax credit for riskiness.

In some types of insurance, moving toward risk rating can lead to an overall reduction in the peril being insured against. For example, charging poor drivers higher premiums is thought to reduce unsafe driving. This benefit may be less likely in health insurance.<sup>5</sup> Since individuals have little ability to change risk factors such as age, heredity, and the course of many diseases, greater alignment of premiums and risk level might do little to increase the overall health status of the population. As the Heritage proposal notes, "The same medical risks are there under our approach as under any other kind of approach."<sup>6</sup>

Greater use of risk rating could also change patterns of cross-subsidization that are implicit in today's market. As described earlier, lower-risk people tend to subsidize higher-risk people when premium levels are unrelated to risk level. Both proposals would tend to replace this cross-subsidy with an explicit transfer from higher-income people to lower-income people through the tax system.

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4. Bureau of Labor Statistics, *Employee Benefits in Medium and Large Private Establishments, 1991*, Bulletin 2422 (May 1993), p. 61; Bureau of Labor Statistics, *Employee Benefits in State and Local Governments, 1990*, Bulletin 2398 (February 1992), p. 53; Bureau of Labor Statistics, *Employee Benefits in Small Private Establishments, 1990*, Bulletin 2388 (September 1991), p. 55.

5. Henry J. Aaron, *Serious and Unstable Condition: Financing America's Health Care* (Washington, D.C.: Brookings Institution, 1991), pp. 34-37.

6. Stuart M. Butler, ed., *Is Tax Reform the Key to Health Care Reform?* (Washington, D.C.: Heritage Foundation, 1991), p. 56.

## INDIVIDUALS AND FAMILIES

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Either proposal would affect the behavior and the financial situation of virtually every person who is covered by private insurance. By changing the incentives that now face individuals and families, either proposal would affect people's purchases of health care and insurance, their willingness to work, and the rewards they receive for that work. The resulting changes in income, taxes, and spending would interact in complex ways to determine the net financial impact for each individual and family.

### Changes in Incentives

Any system of taxation affects the balance of considerations that people weigh when deciding how to earn their livelihoods and spend their incomes. In general, either proposal would mean that consumers would make and pay for their own health spending decisions more directly than they do now. In particular, there would be five substantial changes in the incentives facing consumers. These changes could influence the behavior of enough people that the impacts would be noticeable at the national level, even if they made no difference for many families.

First, out-of-pocket spending on health care would be subsidized in the same way as premiums would be. For most people, current law means that premiums paid by one's employer are untaxed, while out-of-pocket expenses must be paid from after-tax income. (Employees who participate in certain types of flexible benefit plans are exceptions.) This difference has contributed to such anomalies as "insurance" coverage against the cost of dental check-ups and other predictable, low-cost services. Under either proposal, the actual split between spending on premiums and out-of-pocket spending would be irrelevant in calculating a family's tax credit. As a result, out-of-pocket spending would probably account for a higher proportion of an insured family's health expenses.

Second, insurance bought outside the workplace would be subsidized in the same way as employment-based insurance. The current tax exclusion and the provision allowing flexible benefit plans subsidize employed people but not people who are self-employed, unemployed, or who otherwise must pay their own premiums. Both proposals would mean that spending on premiums would draw the same subsidy regardless of whether the policy was bought individually, through an employer, or through some other group. In the absence of other considerations, this change in incentives would make it less likely that the typical family would choose to be insured through the workplace. As discussed previously, however, other features of the proposals

would have important implications for the role of employment-based insurance.

Third, employer-provided insurance benefits would become taxable while certain other fringe benefits would retain their current tax advantages. Just as many employees now prefer to receive \$1 in tax-free health insurance to \$1 in taxable cash income, in the future employees might prefer to receive \$1 in tax-free child care or education benefits to \$1 in taxable health insurance. The magnitude of any such shift would be smaller under the Heritage proposal than under the Pauly group proposal. The reason is that an employee who chose to receive \$1 in taxable health insurance under the Heritage proposal would also receive a tax credit of at least 25 cents. Under the Pauly group proposal, the value of the credit would be unaffected by actual spending on premiums.

Fourth, the value of tax credits could decline as income rose, thus affecting the incentive to work. Under current law, a typical family whose total income from work rises from \$38,000 to \$39,000 retains, at most, \$774 of the \$1,000 increase. Federal income tax claims 15 percent of the increase, while federal payroll taxes claim another 7.65 percent. The combined effect might be called a 22.65 percent marginal disincentive to earn income. State and local taxes, which vary widely, increase this disincentive.

As would any proposal that gears subsidies or taxes to income, the Heritage and Pauly group proposals would increase this disincentive for many families. Under the Heritage proposal, the increase would be zero for families whose health expenses were less than 10 percent of adjusted gross income. It would be 2.5 percentage points for families with health expenses between 10 percent and 20 percent of AGI, and 7.5 percentage points for families whose health expenses exceeded 20 percent of AGI. For example, if a family's income rose from \$38,000 to \$39,000, and if its health spending were \$3,000 in either case, its tax credit would remain unchanged at \$750. But if its health expenses were \$4,500 in either case, its credit would fall from \$1,300 to \$1,275 because of the increased income. Similarly, if its health expenses were \$8,000, its credit would fall from \$3,150 to \$3,075. The new federal/state program directed at people whose incomes are low might also affect the marginal disincentive to earn income. Since each state would design its own program, no generalization is possible.

Under the Pauly group proposal, the marginal disincentive would depend on the value of the base credit as well as on any adjustments to it. For a three-person family of average risk, if the value of the base credit were \$3,000 at the poverty threshold and zero at five times that threshold, the increase in the marginal disincentive to earn income would be 6.9 percentage

points. For example, a family that saw its income rise from \$38,000 to \$39,000 would see its tax credit fall from \$1,126 to \$1,057.

Fifth, through its own actions, a family might have to buy the mandated insurance and incur the associated cost. Under the Heritage proposal, those people on the borderline of Medicaid eligibility might be particularly affected. The wide range in Medicaid rules makes generalization difficult, but an example might be a three-person family that lost its eligibility because its income rose from \$10,000 to \$11,000. It would then have to buy a minimum benefit plan for \$3,250. If its out-of-pocket spending were unchanged at, say, \$200, its tax credit would be about \$1,760, reducing the net cost of the minimum plan to about \$1,490. That is, the cost of insurance after subsidization would more than offset the \$1,000 in increased income, creating a strong incentive to stay on Medicaid. Again, the proposed state program could mitigate this incentive, depending on its design.

Under the Pauly group proposal, the Medicaid program would no longer cover acute care for people under age 65, and people who otherwise would have relied on Medicaid for this coverage would have to buy the minimum benefit plan from a private insurer. The difficulties that might arise in the transition from Medicaid to private coverage under the Heritage proposal would therefore not be an issue under the Pauly group proposal. Since the Pauly group proposal does not specify how the mandate would apply to enrollees in other public programs--such as the military health services system--it is not possible to analyze the incentives that would face these people.

### Financial Effects

The financial impact of either proposal on any individual or family can be broken down into six separate effects. The Heritage proposal would also generate a seventh.

First, people whose employers now offer health insurance benefits could see an increase in cash income. Under the Heritage proposal, employers would have to pay out the value of contributions in cash and allow employees to spend the money as they saw fit. The allocation among employees would be on the basis of age, sex, and geographic residence. Under the Pauly group proposal, it would be up to employers to decide whether to "cash out" the insurance benefits and on what basis to report the value of the benefits to the Internal Revenue Service.

Second, people whose employers provided health insurance benefits would pay more taxes, since federal income and payroll taxes would become payable on the value of those benefits. (The effect of the tax credit is considered separately.) For many people, increased state and local taxes would probably become payable as well. Other things being equal, the increase in taxes would be greater for those people with higher marginal tax rates and those whose employers offer more generous benefits.

Third, people would have to buy the minimum benefit plan in order to meet the mandate. Under the Heritage proposal, the cost of insurance would depend on demographic category and the choice of insurer. Under the Pauly group proposal, it could depend on these factors or any others that insurers cared to use. Because that proposal would require the standard plan to offer more generous coverage for people with lower incomes, premiums would also be higher for lower-income people under the Pauly group proposal, other things being equal.

Fourth, many people would choose to buy supplementary insurance. Under the Heritage proposal, the minimum benefit plan would require policyholders to pay substantially higher deductibles than people commonly pay today. Even though insurance premiums would no longer have tax advantages over out-of-pocket spending, it is likely that many people would prefer to have more financial protection against health costs than the minimum plan alone would offer. Given the many changes that the proposal would make to the health insurance system, it is difficult to predict the popularity or the cost of supplementary insurance. Under the Pauly group proposal, the prevalence of supplementary insurance would depend on the comprehensiveness of the minimum benefit plan, which has not been specified.

Fifth, many people would choose to change the amount of money they spent out of pocket for health care. For those who now have insurance, out-of-pocket spending would probably increase as a proportion of health expenses; for people who are now uninsured, out-of-pocket spending would fall as a proportion of health expenses.

Sixth, people eligible for the tax credit would benefit from it. Under the Heritage proposal, people of every income level would receive a credit equal to at least 25 percent of their health expenses, but few people would receive a credit that completely covered the cost of the minimum benefit plan. Under the Pauly group proposal, the credit would cover the full cost of the minimum benefit plan for people below the poverty threshold but would decline to zero for people above certain income cutoffs.

Seventh, and only under the Heritage proposal, some low-income families would benefit from the new federal/state program. Only people with incomes under 150 percent of the poverty threshold would be affected.

### Illustrative Examples of Impacts

Because of complex interactions among the effects listed above and the uncertainty surrounding such important variables as premium levels, any estimates of the net impacts of the proposals would be speculative. But it is possible to illustrate the mechanics of how the proposals would affect people and to show, in broad terms, the types of effects the proposals could have. The illustrations that follow also point up the more consequential variables.

In each case, the illustration assumes a family of three people, earning income only from employment and claiming three exemptions and the value of the standard deduction on its tax return.<sup>7</sup> State and local taxes are assumed to be zero. Using data from 1991, a typical employment-based plan for such a family is assumed to have an annual premium of \$3,690, of which 85 percent (or about \$3,140) is a nontaxable contribution by the employer. In addition, each family is assumed to spend \$950 out of pocket for deductibles, coinsurance, and other health expenses not covered by insurance. This figure, based on CBO tabulations of the 1987 National Medical Expenditure Survey, represents average out-of-pocket spending for all families of at least three members, all of whom were under 65 years old and insured throughout the year. The estimate was updated to 1991 by the growth in out-of-pocket spending per person from the national health accounts. Using one figure for all families is unrealistic, since out-of-pocket spending varies systematically with income, insurance status, and other variables. Appendix B, which presents similar calculations to those shown here, incorporates estimates of out-of-pocket spending that vary among the families. Regardless of which tables are considered, the analytic comments in this subsection hold true.

Under either proposal, the minimum benefit plan is assumed to cost the typical family \$3,250. Since that coverage is assumed to be less generous than employment-based insurance is today, out-of-pocket spending would probably increase and many families would buy supplementary insurance. In

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7. The illustrations would be more comprehensive if they were expressed in terms of "economic income," which includes all payments made by the employer on behalf of the employee. In the interest of simplicity, however, the illustrations assume that health insurance is the only fringe benefit and they exclude the employer share of payroll taxes. If economic income had been used, the net results would have been the same as those shown in the tables.

order to cover both of these changes, families that now have employment-based insurance are assumed to increase out-of-pocket spending by 45 percent, which in most cases would leave their total health expenses almost unchanged. Total health expenses, of course, might well change if either proposal were put into effect, but any specific estimate would be speculative. (The uninsured family in Table 3 is shown with no increase in out-of-pocket spending, since its deductible, once it became insured, would exceed its previous level of out-of-pocket spending.)

Calculation of the proposed Heritage tax credit is as stipulated in the proposal. Calculation of the Pauly group's proposed credit assumes that the basic credit would be \$3,000; that is, that the lowest-priced premium for the minimum benefits plan for a family of average risk would be \$3,000 even if the average premium were \$3,250. The value of the subsidy is assumed to range from 100 percent of \$3,000 for families with incomes at the poverty threshold to zero for families at five times the threshold.

For example, the two proposals would affect three families of average risk level but differing incomes--\$21,000, \$38,000, and \$55,000--as follows (see Table 2). Under current law, the insurance premium paid for a family is shown as \$3,690, of which the employer pays 85 percent and the family 15 percent.<sup>8</sup> After subtracting the premium as well as income and payroll taxes and out-of-pocket health spending, total compensation, less taxes and health expenses, for the three families is \$16,560, \$29,710, and \$41,810, respectively.

Under either proposal, reported income would increase by the value of the employer's contribution, thus increasing taxes payable. The decrease in the premium paid from \$3,690 to \$3,250 would probably be at least partly offset by the increase in out-of-pocket spending and by spending on premiums for supplementary insurance.

Either proposal would offer greater benefits for people of lower incomes, other things being equal. The inverse relationship can be seen by comparing the "difference from current law" line in Table 2 for families of each income level; the actual numbers are less important than the trend. The relationship would be weaker under the Heritage proposal, since it would give all families a tax credit, while the Pauly group proposal would give families above certain income thresholds no credit.

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8. In 1991, \$38,000 slightly exceeded the median income for a family of three, while \$21,000 was 45 percent below the median income and \$55,000 was 45 percent above it. See Bureau of the Census, *Money Income of Households, Families, and Persons in the United States: 1991*, Current Population Reports, series P-60, no. 180 (August 1992), p. 40.

TABLE 2. ILLUSTRATION OF POSSIBLE IMPACTS OF PROPOSALS,  
BY INCOME OF FAMILY (In dollars)

	Income		
	Lower	Middle	Higher
<b>Current Law</b>			
Income Reported for Tax Purposes	21,000	38,000	55,000
Plus nontaxable premiums	3,140	3,140	3,140
Less income and payroll taxes	-2,940	-6,790	-11,690
Less total premium	-3,690	-3,690	-3,690
Less out-of-pocket spending	<u>-950</u>	<u>-950</u>	<u>-950</u>
Equals total compensation less taxes and health expenses	16,560	29,710	41,810
<b>Heritage Proposal</b>			
Income Reported for Tax Purposes	24,140	41,140	58,140
Less income and payroll taxes	-3,640	-7,490	-12,610
Less total premium	-3,250	-3,250	-3,250
Less out-of-pocket spending and supplementary premiums <sup>a</sup>	-1,380	-1,380	-1,380
Plus health tax credit	<u>1,710</u>	<u>1,290</u>	<u>1,160</u>
Equals total compensation less taxes and health expenses	17,580	30,310	42,060
Difference from Current Law	1,020	600	250
<b>Pauly Group Proposal</b>			
Income Reported for Tax Purposes	24,140	41,140	58,140
Less income and payroll taxes	-3,640	-7,490	-12,610
Less total premium	-3,250	-3,250	-3,250
Less out-of-pocket spending and supplementary premiums <sup>a</sup>	-1,380	-1,380	-1,380
Plus health tax credit	<u>2,080</u>	<u>910</u>	<u>0</u>
Equals total compensation less taxes and health expenses	17,950	29,930	40,900
Difference from Current Law	1,390	220	-910

SOURCE: Congressional Budget Office.

a. For purposes of illustration, families that are currently insured are shown with total spending on health (premiums plus out-of-pocket spending) approximately unchanged. Although such spending probably would change, any specific estimate would be speculative.

As a second illustration, three families might be on the same risk level and earn the same income for tax purposes but have different insurance statuses (see Table 3). One might have employer-provided insurance, another might buy insurance on its own at a higher premium than it would pay as part of a group, and a third might be uninsured. The family that buys its own insurance can deduct some of the cost; otherwise, it is assumed that all three will pay the same taxes.

Under either proposal, the family with employment-based insurance would pay higher taxes but receive an offsetting tax credit. The family that bought insurance on its own would receive a tax credit that exceeded the subsidy it received previously, making it substantially better off. The uninsured family, on the other hand, would have to buy the minimum benefit plan, and the tax credit would offset only part of the cost of the premium. As a result, this family would end up substantially worse off financially, although it would gain the benefits of insurance and, as a result, its use of health care services would probably rise.

Significant uncertainty surrounds the issue of how the proposals would affect families of different risk levels (see Table 4). The net impacts would depend critically on how employers' current contributions were included in reported income, how premiums varied to reflect risk under either proposal, and, under the Pauly group proposal, how the tax credit was adjusted to reflect risk.

For the sake of illustration, a lower-risk family would be a three-person family living in one of the West Coast states, with both parents in their early 30s. An average-risk family might include parents in their early 40s, living in Ohio or Illinois. A higher-risk family might include parents approaching 50 years old, living in New York or Pennsylvania. Reported income is the same for each family, and each family has employment-based insurance.

As discussed previously, there are at least two defensible methods of estimating the value of each family's current insurance, and the method chosen would make a significant difference to the family. The illustration of current law follows the Heritage proposal in imputing higher value to coverage of a higher-risk person than to the same coverage of a lower-risk person. The premium for the lower-risk family is shown as 35 percent below the average premium, while that of the higher-risk family is shown as 35

TABLE 3. ILLUSTRATION OF POSSIBLE IMPACTS OF PROPOSALS,  
BY CURRENT INSURANCE STATUS OF FAMILY (In dollars)

	Employer Purchase	Individual Purchase	Uninsured
<b>Current Law</b>			
Income Reported for Tax Purposes	38,000	38,000	38,000
Plus nontaxable premiums	3,140	0	0
Less income and payroll taxes	-6,790	-6,350	-6,790
Less total premium	-3,690	-4,780	0
Less out-of-pocket spending	<u>-950</u>	<u>-950</u>	<u>-950</u>
Equals total compensation less taxes and health expenses	29,710	25,920	30,260
<b>Heritage Proposal</b>			
Income Reported for Tax Purposes	41,140	38,000	38,000
Less income and payroll taxes	-7,490	-6,790	-6,790
Less total premium	-3,250	-3,250	-3,250
Less out-of-pocket spending and supplementary premiums <sup>a</sup>	-1,380	-1,380	-950
Plus health tax credit	<u>1,290</u>	<u>1,370</u>	<u>1,150</u>
Equals total compensation less taxes and health expenses	30,310	27,950	28,160
Difference from Current Law	600	2,030	-2,100
<b>Pauly Group Proposal</b>			
Income Reported for Tax Purposes	41,140	38,000	38,000
Less income and payroll taxes	-7,490	-6,790	-6,790
Less total premium	-3,250	-3,250	-3,250
Less out-of-pocket spending and supplementary premiums <sup>a</sup>	-1,380	-1,380	-950
Plus health tax credit	<u>910</u>	<u>1,130</u>	<u>1,130</u>
Equals total compensation less taxes and health expenses	29,930	27,710	28,140
Difference from Current Law	220	1,790	-2,120

SOURCE: Congressional Budget Office.

a. For purposes of illustration, families that are currently insured are shown with total spending on health (premiums plus out-of-pocket spending) approximately unchanged. Although such spending probably would change, any specific estimate would be speculative.

TABLE 4. ILLUSTRATION OF POSSIBLE IMPACTS OF PROPOSALS,  
BY RELATIVE RISK LEVEL OF FAMILY (In dollars)

	Relative Risk Level		
	Low	Average	High
<b>Current Law</b>			
Income Reported for Tax Purposes	38,000	38,000	38,000
Plus nontaxable premiums <sup>a</sup>	1,860	3,140	4,440
Less income and payroll taxes	-6,790	-6,790	-6,790
Less total premium <sup>a</sup>	-2,410	-3,690	-4,990
Less out-of-pocket spending	<u>-950</u>	<u>-950</u>	<u>-950</u>
Equals total compensation less taxes and health expenses	29,710	29,710	29,710
<b>Heritage Proposal</b>			
Income Reported for Tax Purposes	39,860	41,140	42,440
Less income and payroll taxes	-7,200	-7,490	-7,790
Less total premium <sup>b</sup>	-2,120	-3,250	-4,390
Less out-of-pocket spending and supplementary premiums <sup>c</sup>	-1,380	-1,380	-1,380
Plus health tax credit	<u>870</u>	<u>1,290</u>	<u>1,830</u>
Equals total compensation less taxes and health expenses	30,030	30,310	30,710
Difference from Current Law	320	600	1,000
<b>Pauly Group Proposal</b>			
Income Reported for Tax Purposes	39,860	41,140	42,440
Less income and payroll taxes	-7,200	-7,490	-7,790
Less total premium <sup>b</sup>	-2,120	-3,250	-4,390
Less out-of-pocket spending and supplementary premiums <sup>c</sup>	-1,380	-1,380	-1,380
Plus health tax credit	<u>d</u>	<u>910</u>	<u>d</u>
Equals total compensation less taxes and health expenses	d	29,930	d
Difference from Current Law	d	220	d

SOURCE: Congressional Budget Office.

- a. Assumes that the value of insurance varies with risk level; as well, each family is assumed to pay the same amount (\$550) toward its premium.
- b. For purposes of this table, the range of premiums is assumed to be the same under both proposals.
- c. For purposes of illustration, families that are currently insured are shown with total spending on health (premiums plus out-of-pocket spending) approximately unchanged. Although such spending probably would change, any specific estimate would be speculative.
- d. Cannot be estimated from information available.

percent above it.<sup>9</sup> Under the Heritage proposal, the premiums charged to families of differing risk levels would tend to parallel the increases in reported incomes; in the illustration, premiums for the lower-risk and higher-risk families are arbitrarily shown as 35 percent below the average and 35 percent above it, respectively. The same figures are used for the Pauly group proposal, although in practice the variability in premiums could well differ between the two proposals.

Under these assumptions, the Heritage proposal could bring greater benefits to people of higher risk levels, largely because the marginal subsidy rate would rise as health expenses accounted for a greater proportion of income. How well the Pauly group proposal would fit the circumstances of families of differing risk levels cannot be inferred from the proposal.

## HEALTH SPENDING

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Both proposals, compared with the current system, might constrain health spending, although this outcome cannot be predicted with confidence. Spending by people now insured might be reduced below levels it otherwise would have reached; this effect would be offset by increased spending by people who would become insured. These statements apply both to total spending and to spending on an average basis, whether that would be per person or per service.

The essential change would be that most people would pay for their health spending decisions more directly and would benefit more directly from any savings. As well, the standardization of the minimum benefit plan would make it easier for consumers to shop and compare insurers.

The incentives to economize would be stronger under the Pauly group proposal. Under the Heritage proposal, each extra dollar of spending would be partly subsidized, with the marginal subsidy rate ranging from 25 percent to 75 percent. Under the Pauly group proposal, an additional dollar spent on health would not affect the size of the tax credit, leaving the individual to bear the full cost. As intended by the Pauly group, tax considerations would not affect individual decisions about how much of one's income to devote to health.

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9. In keeping with the prevailing practice in today's market, the illustration implicitly has each family making the same contribution (\$550) to the total premium. Consequently, the employer contributes 78 percent of the premium for the lower-risk family, 85 percent for the average-risk family, and 89 percent for the higher-risk family.

Possible effects on national health spending can be analyzed by considering first the impacts on the health care market and then the impacts on the insurance market. Impacts on the health care market, in turn, can be separated into demand-side and supply-side effects. In the insurance market, costs consist of claims, which depend in large part on trends in the health care market, and administrative expenses.

Looking at the health care market, there would be two major offsetting influences on the demand for health care. First, many of the approximately 148 million people who now have employment-based insurance would have incentives to demand less care. Since they would pay their insurance and out-of-pocket costs directly, many families would be more selective in deciding whether to seek care and what price to pay. Many people might join health maintenance organizations and other forms of managed care; those who retained indemnity-style coverage might accept higher deductibles and coinsurance. These changes would probably result in at least a one-time drop in health care spending, although the effect on the growth rate would be less clear.<sup>10</sup>

Second, about 37 million uninsured people would become insured, thus increasing their demand for health care. The magnitude of any increase in spending among those now uninsured would depend critically on the type of coverage they obtained. Coverage of only catastrophic expenses, as envisioned in the Heritage proposal, could be expected to increase demand by less than coverage with a low deductible amount.

Without more information, one cannot predict whether the increase in demand by people now uninsured would outweigh the decrease in demand by people now insured. The volume of health care services used and their prices would also be affected by the supply side of the market, that is, by the availability of physicians, hospital beds, and so forth. Given the magnitude of the possible changes in demand, it cannot be presumed that prices charged by health care providers would be unaffected.

Turning to the insurance market, the net impact on spending would be even less clear. Although the number of insurance policies written would rise because more people would buy insurance, the overall amount of insurance coverage demanded (as measured, for example, by the total amount of premiums people would be willing to pay) could rise or fall. People who are

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10. See Congressional Budget Office, "Effects of Managed Care: An Update," CBO Memorandum (March 1994), and Congressional Budget Office, *Rising Health Care Costs: Causes, Implications, and Strategies* (April 1991), pp. 34-36.

now insured would have incentives to demand less comprehensive coverage, while people who are now uninsured would have to buy coverage.

On the supply side, the availability of insurance would be affected by insurers' costs for claims and administration. Claims can be presumed to reflect trends in underlying health care costs, as discussed above. The most relevant administrative expenses for the purposes of this memorandum would be the costs of marketing, risk assessment, and processing claims. In these areas, the proposals could have very different effects.

Under the Heritage proposal, the purchase of insurance would tend to become an individual decision, and insurers might have to incur substantially higher marketing expenses than under the Pauly group proposal. Under that proposal, group-based insurance would be more prevalent, so insurers would be more likely to benefit from economies of scale in marketing.

Risk-assessment expenses, on the other hand, would probably be considerably lower under the Heritage proposal, since insurers would have to accept all applicants and could vary premiums only to reflect easily obtainable demographic information. The Pauly group proposal could lead to an increase over today's risk-assessment costs, since insurers serving the individual and small-group markets would have strong incentives to ascertain risk and set premiums accordingly.

Both proposals would have ambiguous effects on the costs of claims processing, which are driven chiefly by the number of claims made. The population that became insured would generate claims, of course, but this increase could be modest if most of these people carried coverage of catastrophic expenses only. People who are now insured, many of whom would probably choose less comprehensive coverage under either proposal, might file fewer claims than they would have under current law.

## GOVERNMENT FINANCES

Both proposals would lead to major changes in federal and state revenues and outlays and in federal-state fiscal relations. Although estimation of these effects is beyond the scope of this memorandum, the likely changes can be described in general terms.

For the federal government, under either proposal, the major revenue increase would stem from the elimination of the current tax subsidies for health spending, net of the revenue loss from taxpayers redirecting spending to uses that would remain tax-preferred. The major revenue loss would be

the proposed tax credit. The sheer size of these changes would mean that estimation errors could have multibillion-dollar consequences. Furthermore, under both proposals the cost to the federal government of the tax credit would be particularly hard to predict, since it would depend on premiums charged by private-sector insurers operating in a market quite different from today's.

Under the Heritage proposal, the cost of the tax credit would depend on the sum of the population's spending on the minimum benefit plan, supplementary plans, and eligible out-of-pocket expenses--and on whether the people incurring these expenses were in the 25 percent, the 50 percent, or the 75 percent marginal subsidy bracket. Under the Pauly group proposal, the cost of the credit would depend on the premiums charged by the fallback insurers in each part of the country and on the (unspecified) mechanism for adjusting the basic credits for risk level. Since fallback insurers would be quoting premiums for the particular segment of the population that does not seek insurance itself, these premiums--and therefore, the cost of the tax credit--might vary substantially and unpredictably from year to year.

In addition, the Heritage proposal would change the Medicaid and Medicare programs to reduce outlays below the levels they would have had under current law. The most important of these changes would probably be the proposed cap on the federal contribution to the acute care portion of each state's Medicaid program, since the federal government has hitherto shared the financing of rapidly growing expenditures in an open-ended fashion. The cap would also tend to make permanent the share of federal spending on acute care services that each state now receives. Under current law, the overall federal contribution for each Medicaid beneficiary varies by a factor of three among the states, depending on each state's spending and on the federal matching percentage, which in turn depends on income per person in each state.<sup>11</sup>

The Heritage proposal also calls for ending disproportionate share hospital payments that are now made by both the Medicare and Medicaid programs. Instead, the federal government would make block grants that states would use to assist people with low incomes and for other purposes. Although the proposal specifies funding levels for the federal government, obligations placed on the states would depend on a formula that would leave

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11. This calculation is based on all Medicaid spending, not just that for acute care, and is for fiscal year 1991. Calculated from data in 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), pp. 119-20 and 485-86.

room for states to minimize these obligations. The federal government would be authorized to spend \$14.2 billion on the program in fiscal year 1997 (rising to \$20 billion three years later), and each state would have to spend in fiscal year 1997 what it spent on DSH payments the previous year, updated for inflation. States would therefore have strong incentives to limit DSH payments in fiscal year 1996. Even without this incentive, state DSH payments are difficult to predict. Both the Omnibus Budget Reconciliation Act of 1993 (P.L. 103-66) and the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments (P.L. 102-234) made important changes in related state financing options that affect DSH payments.

The Heritage proposal would affect state and local finances in three other ways. First, state and local governments with income tax regimes similar to federal law could gain increased revenue from the increased proportion of employees' compensation that would become subject to taxation. This benefit to state and local budgets would be offset if allowance was also made for the proposed federal tax credit.

Second, the greater number of insured patients would mean that state and local governments would face lower bills for uncompensated care. The magnitude of the decrease would depend on how many people remained uninsured and the comprehensiveness of the minimum benefit plan for the people who became insured.

Third, state governments would incur the costs of identifying people who had no insurance, of collecting premiums from them, and of covering the difference between premium revenue and the cost of coverage. Although the federal government could withhold all funding for health programs from states that did not meet these responsibilities, the lack of intermediate sanctions would leave room for some states to devote only minimal effort to these tasks.

Under the Pauly group proposal, federal and state Medicaid spending would be lower than under current law. The magnitude of the decrease would depend on the extent to which the minimum benefit plan supplanted acute care benefits for Medicaid beneficiaries. But since the proposal does not specify the contents of the minimum plan, the impact on outlays cannot be addressed. The proposal would also reduce state and local government liabilities for uncompensated care; again, the magnitude of any reduction would depend on the specifications of the minimum benefit plan.