

Market Structure, Adverse Selection, and Risk Adjustment

The issue of how effectively community-rated markets would function has been a concern in all the health care proposals that CBO has analyzed. If the average health status of enrollees varied significantly among health plans, plans with less healthy enrollees would have difficulty competing unless appropriate steps could be taken to compensate them for their higher-risk clientele. But the development and implementation of reliable risk-adjustment mechanisms is likely to remain an elusive goal, at least in the immediate future.

The problems of adverse selection could become more severe as people's health insurance choices expanded, giving them greater opportunities to self-select into groups according to their health status and preferences for health care. Depending on the proposal, those choices could be of four basic kinds:

- o whether to obtain health insurance at all, a choice that arises only in proposals that do not mandate health coverage;
- o what market institution or agent to use, a choice that arises in all proposals that do not mandate the use of a single purchasing organization;
- o what benefit package to choose, a choice that arises in proposals that do not require a single standard benefit package; and
- o what type of plan to choose--for example, a plan that allows an unlimited choice of providers versus an HMO.

Since Congressman Gephardt's proposal would require everyone to have insurance coverage, the decision whether to participate would not be an issue. But the other three types of choices would all arise.

Assessing possible responses to those choices is difficult, both because of the range of options that individuals and small employers would face and because of ambiguities in the bill. Not only could individuals and small employers choose between Part C and private insurance, but those selecting private insurance could purchase it directly from insurance companies, through the universal FEHBP, through a purchasing cooperative (if one was established), through association plans (if they were members of an

association sponsoring a plan), or through state-sponsored enrollment sites. Some people enrolled in private-sector plans could also choose between standard and catastrophic coverage.

Although Medicare Part C is clearly intended to be outside the community-rated market, the status of some of the private-sector purchasing options is uncertain. Resolving their status is important because risk adjustment would occur only within the community-rated market. The proposal's apparent intent is that all individuals and small employers purchasing private health insurance should participate in the risk-adjustment process, and that is what CBO assumed in its estimates. This requirement would reduce the problems of adverse selection that would arise if some of the purchasing options were excluded. But the existence of multiple purchasing arrangements would complicate the process.

It is also unclear whether risk adjustment would occur across plan types within the community-rated market. If risk adjustment was implemented within but not between plan types, the option to choose catastrophic coverage would provide another avenue for adverse selection.

Because Medicare Part C would be the default insurer for anyone who did not have private coverage, that program might enroll an unfavorable risk pool. But that conclusion is by no means certain. Some of the uninsured who did not seek out coverage, and ended up in Part C by default, would be young and healthy. By contrast, some subsidized people with poor health would probably take advantage of the option to purchase insurance outside Part C. As discussed below, however, the lack of risk adjustment between the private sector and Part C means that the potential for unstable premiums and enrollment in either Part C or the community-rated pool is significant. That result could occur if either pool experienced serious problems with adverse selection at the expense of the other.

The Path of Premiums and the Sustainability of the System

CBO's estimates of Congressman Gephardt's proposal assume that Medicare Part C and a private, community-rated health insurance market could coexist over time with no risk adjustment between them. This assumption in turn embodies additional assumptions about the relationship between the premiums for Part C and those for private insurance.

Initial Premiums and Subsequent Growth. Whether individuals and small employers would have a meaningful choice between public and private-sector insurance coverage would depend on the relationship between Part C

premiums and private premiums--initially and over time. A variety of scenarios is possible. For example, Part C premiums might start out higher than private premiums, in which case few people would choose to enroll except for those who were fully subsidized (and who therefore would not have to pay any of the difference in the premiums) and those who ended up in Part C by default because they did not actively seek out a private plan. In these circumstances, the program might never expand beyond a very limited base.

Alternatively, Part C premiums might start out lower than private premiums but grow more rapidly because, say, of adverse selection. In that case, Part C would lose enrollees over time as its competitive advantage evaporated. The higher rate of growth would mean that Part C premiums would eventually exceed private premiums, again resulting in an enrollee base composed primarily of people whose premiums were fully subsidized.

A third scenario--the one assumed by CBO--is that lower reimbursement rates and more effective cost containment would result in premiums for Part C starting out lower than private premiums and growing more slowly. Achieving the long-run rate of enrollment in Part C would take several years under this scenario. The proposal requires, however, that initial premiums be set on the basis of the program's ultimate enrollment. That assumption would probably result in premiums that reflected a population with lower average risk than the initial enrollees in Medicare Part C. Consequently, additional outlays would be necessary to make up the shortfall in the first few years.

A variation on the previous scenario that cannot be ruled out is that the gap in growth rates between Part C and private premiums might be much larger than CBO has assumed. In that case, Part C enrollment would increase more quickly than assumed here, and the Part C program could eventually become the dominant insurer for individuals and small firms and possibly their only choice in some markets.

Sources of Uncertainty. The federal outlays required to make up the shortfall in Part C premiums in the early years of the program would--in effect--constitute additional premium subsidies to Part C enrollees. If Part C enrollment (and the corresponding risk composition of enrollment) did not reach the levels assumed by CBO or did not do so as rapidly, the federal government might have to continue such subsidies indefinitely. Letting Part C premiums rise to their actuarially correct level would only exacerbate the situation, because such an increase would further slow (or reduce) growth in enrollment while converting outlays to cover premium shortfalls into direct subsidies for low-income families enrolled in Part C. In addition, higher

Part C premiums would increase federal outlays for subsidies to people enrolled in private plans.

Considerable uncertainty also surrounds the assumption that Medicare Part C would constrain the health spending of its enrollees more effectively than would private insurance plans. Alternative assumptions about the relative effectiveness of the cost containment measures would have important implications for subsidy costs.

Depending on how it occurred, cost containment in the private sector that proved more successful than CBO assumed could either increase or decrease federal subsidies. Subsidies would increase if private-sector cost containment resulted from preferential risk selection, which caused more higher-risk people to enroll in Part C. As Part C premiums rose to reflect the changing mix of risks, a greater fraction of private premiums would be subsidized. Subsidies would decrease if more effective containment of private-sector costs resulted from reduced spending per capita (say, because of lower reimbursements to providers). At the same time, however, more effective containment of private-sector costs would reduce people's incentives to enroll in Part C.

Cost containment under Part C that was less effective than CBO assumed would have two effects. First, it would reduce people's incentives to enroll in Part C, thus increasing costs and subsidies for Part C enrollees. Second, it would increase subsidies to people in private plans even if Part C remained less expensive than those plans (because subsidy amounts would depend on the level of the Part C premium).

Insurance Costs for Moderate-Sized Firms

Under Congressman Gephardt's proposal, participation in the community-rated market would be restricted to individuals and employees of firms with 100 or fewer employees. Participation in Medicare Part C would be restricted to those groups plus AFDC and SSI beneficiaries, as well as part-time, seasonal, and temporary employees. Larger firms would have to self-insure or offer experience-rated coverage obtained from an insurance carrier.

Moderate-sized firms (those with, say, 101 to 200 employees) might face relatively high premiums under this structure, not only because they would be experience-rated but also because of the requirement that they offer their employees a choice of at least two plans. The same types of concerns have arisen with other proposals that have similar provisions. But the potential problems are particularly pronounced in Congressman Gephardt's

proposal because a firm's size would be determined by the total number of employees--both full-time and part-time--rather than the number of full-time or full-time-equivalent employees. Enrollment in some employers' plans could therefore be extremely small because part-time employees, as well as employees in families with two workers, could obtain coverage elsewhere.

Small enrollments would result in high administrative costs. Also, one employee with a costly medical problem could raise a plan's premiums significantly. Some plans could end up with increasing premiums and shrinking enrollment as employees either switched to a cheaper plan offered by the firm or sought coverage elsewhere, if they had that option. In some cases, any plans offered by the firm could prove quite expensive.

Insurance Costs for Federal Employees

The proposal's FEHBP and universal FEHBP provisions could result in some federal employees paying more for health insurance, although the effects would vary in markets across the country. The intent of the provisions is to allow people who would be eligible to enroll in community-rated health plans to have access to the same choices as federal employees. Ultimately, federal employees would all be enrolled in universal FEHBP plans and would be charged the same premiums as everyone else enrolled in those plans, but the integration would take place over a period of seven years. At the end of that period, federal employees would no longer have the choice of enrolling in national plans as they do today; they could enroll only in universal FEHBP plans offered in their community-rating area.

The federal employees who might end up paying more under this structure are those who live in high-cost markets and who can currently obtain lower premiums by enrolling in national rather than local FEHBP plans. But some federal employees in relatively low-cost markets might find themselves better off, with a wider range of health insurance choices available at local community rates. Many other federal employees might initially be better off because the federal government would pay a higher percentage of their premium than at present, reflecting the requirements of the mandate on employers. Over time, however, wages or other fringe benefits would probably adjust to reflect the increased share of compensation going to health care.

Effects on HMOs

Most health care proposals would affect the market position of HMOs relative to fee-for-service plans in a variety of ways. Because Congressman Gephardt's proposal would build on the Medicare model to expand health insurance coverage, some analysts believe that it would promote fee-for-service medicine relative to managed care--since Medicare is still primarily a fee-for-service program. Extrapolating from Medicare's experience in the managed care market to Part C is risky, however, because Part C's enrollees would be so different from the current Medicare population. (The fact that only a small percentage of current Medicare beneficiaries enroll in HMOs may be more a reflection of the preferences of the elderly and disabled populations than an inherent feature of the program.) The proposal actually contains a variety of opportunities, incentives, and disincentives for people to enroll in managed care or indemnity plans. It also includes some provisions that might weaken HMOs' ability to contain their costs.

Part C enrollees could select an HMO, if HMOs chose to participate in the program. HMOs would be paid in essentially the same way as they are today by Medicare; that is, for each enrollee, HMOs would receive about 95 percent of the average per capita cost of comparable Part C enrollees in their community who were not enrolled in HMOs. The willingness of HMOs to participate under those conditions would depend on the relationship between their average costs for Part C beneficiaries and Medicare's payment (and would reflect their success in enrolling relatively healthy Part C beneficiaries).

Private-sector enrollees could select a health plan that offered an unlimited choice of providers (a UCP plan) or an HMO, if one was available. That provision would expand choice for all people whose employers currently offer only one plan. Since employers are increasingly shifting away from indemnity coverage to managed care, more people would probably continue to have access to UCP plans than would have in the absence of the requirement to provide a choice of plans.

The incentives for Part C and private-sector enrollees to join an HMO would differ considerably. Part C enrollees would pay the same "premium" through the tax system regardless of the type of plan in which they enrolled. Consequently, the only costs they would be concerned about would be deductibles, coinsurance, and copayments. Because the UCP standard option would have relatively high cost-sharing requirements, an HMO would probably be an attractive option to moderate-income families who were ineligible for cost-sharing subsidies and could not afford to purchase a cost-sharing supplement. Private-sector enrollees, by contrast, would base their cost comparisons on premiums as well as cost sharing--much as they do today.

Employers offering private-sector plans would, however, be required to contribute at least 80 percent of the premium of the lowest-cost plan of each type, possibly reducing the incentives for their employees to select the lowest-cost type of plan.

The extensive subsidies for cost sharing in Congressman Gephardt's proposal would significantly reduce incentives to enroll in HMOs, regardless of whether the eligible populations were enrolled in Part C or the private sector. Unlike some other proposals with cost-sharing subsidies, this one would not generally require people who were eligible for subsidies to pay even nominal cost-sharing amounts, essentially providing them with first-dollar coverage--that is, coverage with no deductibles, coinsurance, or copayments. (The subsidies would be based on the applicable cost-sharing amounts under Medicare Part C.)

The proposal would also place several requirements on HMOs that would restrict their ability to control costs through tightly managed networks of providers. Some of those provisions were incorporated in other proposals. Examples include requiring HMOs to contract with an extensive range of so-called essential community providers and centers of excellence; prohibiting HMOs from requiring women to obtain referrals to obstetricians and gynecologists; and requiring all HMOs that use networks of providers to allow any licensed provider to participate on the same terms as other providers in the network. (Because of some qualifying language in the bill, it is unclear how the latter requirement would actually be interpreted.)

Responsibilities of the Federal and State Governments

Most proposals to restructure the health care system incorporate major additional administrative and regulatory functions that new or existing agencies or organizations would have to undertake. Questions arise, therefore, concerning the capabilities of government agencies to fulfill their responsibilities.

The federal government would play a larger role in the health care system under Congressman Gephardt's proposal than under most other recent health care proposals. The greater federal involvement would result from the proposal's extremely complex regulatory structure, the establishment and operation of Medicare Part C, and the proposed approach to implementing the system of subsidies. The states would also have important new tasks to perform, but because they would not be responsible for implementing the subsidy system, they would have fewer obligations than under some other proposals.

Since the enrollment process for Medicare Part C would be run primarily through the tax system, the Treasury would assume major new responsibilities under this proposal. It would have to track the tax obligations of individuals enrolled in Medicare Part C at some time during the year, taking into account the reduced tax obligations of those eligible for subsidies. In addition, it would have to track the Part C taxes owed by employers, including employers' tax obligations for their nonenrolling employees.

The Department of Health and Human Services would also have a greatly expanded role. It would be responsible for paying Part C claims, issuing and redeeming vouchers for premium subsidies for low-income people enrolling in private plans, administering cost-sharing subsidies for low-income people enrolled in Part C and private plans, and developing and implementing the cost containment initiatives for the private sector and Part C. (Presumably some of those tasks could be contracted out to private-sector organizations, just as claims processing is handled under Medicare now.) In addition, the department would bear the primary responsibility for setting standards for certifying health plans' data systems and quality assurance mechanisms, developing and implementing a system for verifying enrollment, establishing a reporting system for national health expenditures, designing supplemental benefit packages, and developing model risk-adjustment mechanisms.

Similarly, the Department of Labor and the Office of Personnel Management would carry out important functions. The former would be responsible for certifying and monitoring self-insured health plans and operating a reserve fund to pay the claims of insolvent plans; the latter would design and implement the universal FEHBP and integrate it with FEHBP, which would be an extremely complicated undertaking.

Although states could develop single-payer or managed care systems, operate state reimbursement systems, or establish purchasing cooperatives, they would be under no obligation to do so. They would, however, have to assume a variety of responsibilities related to the effective functioning of the health insurance markets and quality assurance. States would, for example, certify health plans, provide uniform information for consumers on all insured health plans, provide enrollment assistance and establish enrollment sites, and set up guaranty funds to pay the claims of insolvent carriers. They would also monitor health plans' compliance with quality assurance requirements, assess patients' satisfaction, and publish annual reports on the performance of health plans.

The Effects on Health Spending by Employers

Congressman Gephardt's proposal would maintain the central role of employers in financing health care but would alter the distribution of costs among employers and workers. Total spending by employers would increase significantly because they would have to pay for insurance for workers who are currently uninsured. CBO estimates that in 2000, all employers together would pay over \$110 billion more for health insurance under this proposal than if the current system continued unchanged. The increase in spending would be even larger in subsequent years, exceeding \$170 billion a year by 2004.

Even though the proposal would raise the overall cost of health insurance for employers, it would have widely differing effects on individual firms and industries, raising costs in some cases and reducing them in others. Three factors account for most of the diversity. First, the requirement for all employers to contribute to health insurance would raise spending by firms that currently do not. Second, the requirement for small firms to participate in either Medicare Part C or the private, community-rated market would probably raise the insurance costs of small firms employing younger, healthier workers and lower them for small firms employing older, less healthy workers. Third, the temporary subsidies to small firms with low average wages would reduce their cost of insurance relative to the cost faced by larger firms or firms with higher average wages.

Who Ultimately Pays for Health Spending by Employers?

Although employers initially pay a large portion of the bill for health insurance, other people ultimately bear these costs. Workers may pay them in the form of lower wages, consumers in the form of higher prices, and shareholders through lower returns on their investments. But economic theory and empirical research both indicate that workers bear most of the cost of employers' premiums for health insurance. Thus, the significant increase in costs that Congressman Gephardt's proposal would produce compared with current policy would be largely passed on to workers in the form of lower wages.

This increase could be particularly burdensome for families with low income. For example, consider a family of one adult and two children, with income just below the poverty threshold in 2000. If the adult worked at a firm with more than 50 full-time employees, the firm would pay more than \$5,400 on the worker's behalf for insurance (80 percent of CBO's estimated single-parent premium in that year); that amount would represent roughly 45

percent of the family's income. If the adult worked at a smaller firm with average wages below \$26,000, the firm's payment would be reduced by up to \$2,700 but would still represent more than 20 percent of the family's income. At those prices, the family might well have preferred not to buy insurance at all, especially if it could obtain publicly provided emergency care for serious health problems, as many people can today.

Effect on Job Opportunities of Certain Minimum-Wage Workers

Although most workers would bear the mandated insurance costs through lower wages, the cash wages of workers earning close to the minimum wage could not fall. As a result, the net cost of employing those workers would increase under this proposal, and fewer adult low-wage workers would be able to find jobs.

Under Congressman Gephardt's proposal, the cost of employing minimum-wage workers would increase significantly above the \$4.57 per hour that employers currently pay to cover the federal minimum wage and their portion of the payroll tax. For example, in 2000, unsubsidized employers would have to pay a minimum of \$6.25 per hour for a single worker and \$8.40 per hour for an enrolling family worker. Moreover, the subsidies for small firms with low average wages would not greatly reduce those hourly costs on average because the subsidies would apply to only a limited group of minimum-wage workers, would be less generous than the subsidies in other health proposals (such as the Administration's), and would be phased out over time.

Some employers would respond to those higher costs by hiring fewer adult minimum-wage workers. Although estimates of such impacts are highly uncertain, the number of employed adult minimum-wage workers could fall by half a million once the economy had fully adjusted to those higher costs. (That estimate is relative to employment levels in the absence of the proposal and, in some respects, may be conservative.)

Those losses in jobs for adults might be partly offset by job gains among other workers. For example, firms might replace some of their low-wage adult workers with more highly skilled workers; or they might employ teenagers under 18 or full-time students under 24, who would be exempt from the mandate. Although economic theory does not suggest an unambiguous gain in jobs for teenagers or other workers and the empirical literature on the subject is not extensive, the few empirical studies that exist tend to confirm such a substitution.

Work Disincentives

The proposal would discourage certain low-income people from working more hours or, in some cases, from working at all. This disincentive for work arises from two features of the proposal--the treatment of nonworkers and the phaseout of family subsidies as family income increases. It is important to note, however, that work disincentives are an inherent feature of all health proposals that target subsidies toward the poor and near poor, and those subsidies could improve the well-being of many low-income people by assisting their purchase of health insurance.

Treatment of Nonworkers. The proposal would create an implicit tax on work because it would make health coverage universal without charging many nonworkers for the full cost of their insurance. Specifically, nonworkers in low-income families would receive sizable subsidies for the purchase of insurance; their coverage would not depend on whether they worked and paid the premium or stayed at home and paid much less. The premium would simply reduce take-home pay without, from the point of view of the individual worker, buying anything. The current system also discourages some of these people from working at firms that pay for insurance, but by requiring more firms to provide insurance coverage and granting full coverage to nonworkers, the proposal would increase the number of people who were affected.

Of course, the vast majority of workers would nevertheless remain in the labor market because they need wage and salary income to support themselves or their families. But people whose spouse is employed are more responsive to changes in work incentives because they can rely on their spouse's income. This proposal would reduce the participation of these workers in the labor force.

Phaseout of Subsidies. The proposal would reduce subsidies to low-income families as their income increased, creating an implicit tax on their economic advancement. With some exceptions, families with income below a threshold amount, which would be set roughly at the poverty level, could receive a full subsidy for any portion of their premium not paid for by an employer. In 1999 through 2001, the subsidy would be phased out as family income rose from the threshold amount to twice that amount. The upper end of this range would increase somewhat in later years, reaching roughly 240 percent of the poverty level in 2004.

Workers who earned more money within the phaseout range would have to pay more for health insurance, which would cut into the increase in their take-home wage. Rough calculations suggest that in 2000, the effective marginal tax on labor compensation would increase by 7 to 9 percentage

points for workers at firms that paid 80 percent of the Medicare Part C premiums. Workers at firms that paid a larger share of the premiums would face a lower tax rate, and workers whose insurance premiums were lower than the Medicare Part C premiums would face the same rate over a smaller income range.

In 2004, the increase in marginal tax rates would be slightly lower than in 2000 because the subsidy would be phased out over a wider range of incomes. At the same time, the expansion of the phaseout range means that more workers would be affected by the increase in marginal rates.

Reallocation of Workers Among Firms

Like several other health care proposals, this one would encourage some reallocation of workers among firms in ways that would increase its budgetary cost. This sorting would occur because small firms with low average wages would receive a credit for some of their required payments; therefore, workers employed by such firms could receive larger take-home salaries than if they were employed by a firm that did not receive a credit.

Nevertheless, two features of the credit make the incentive for worker reallocation in the Gephardt proposal much smaller than the corresponding incentive in most other reform proposals. First, the amount of the credit is not very large. The maximum credit is 50 percent of health insurance costs and applies to the smallest firms with the lowest average wages; the credit is phased out for firms that are larger or have higher average wages. Second, the credit is temporary, so the benefit of worker reallocation would not persist for very long.

Table 1. Estimated Federal Budgetary Effects of Congressman Gephardt's Proposal
(By fiscal year, in billions of dollars)

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
MANDATORY OUTLAYS										
Medicaid										
1 Discontinued Coverage of Acute Care	a	a	a	a	-66.7	-99.4	-110.9	-123.1	-136.5	-150.7
2 State Maintenance-of-Effort Payments	0	0	0	0	-45.7	-65.3	-69.9	-71.8	-68.8	-73.6
3 Administrative Savings	0	0	0	0	-0.5	-0.8	-0.9	-1.0	-1.1	-1.2
4 Emergency Benefits for Aliens	0	0	0	0	0	0	0	1.1	1.6	1.8
Total Medicaid	a	a	a	a	-112.9	-165.5	-181.7	-194.8	-204.8	-223.7
Medicare Parts A and B										
5 Drug Benefit (Net of premiums and rebate)	0	0	0	5.8	13.5	14.6	16.1	17.6	19.3	21.1
6 Out-of-Pocket Cap	0	0	0	0	0	0	0	0	0	0
7 Repeal of Hospital Day Limits	0	0	0	0.2	0.3	0.3	0.4	0.4	1.0	1.3
8 Additional Medicare Savings										
Indirect Medical Education	0	0	0	0	-0.8	-1.7	-2.0	-2.2	-2.4	-2.7
Disproportionate Share Adjustment	0	0	0	0	-1.0	-2.4	-2.8	-3.1	-3.4	-3.7
Inpatient Hospital Capital	0	-0.7	-0.7	-0.7	-0.8	-0.8	-0.9	-1.0	-1.1	-1.2
Payments for Physician Services in Certain Hospitals	0	0	0	-0.5	-0.8	-0.8	-0.8	-0.9	-1.0	-1.0
Home Health Services Coinsurance	0	0	0	-3.0	-4.7	-5.3	-5.8	-6.2	-6.8	-7.3
Home Health Cost Limits	0	0	-0.3	-0.4	-0.5	-0.5	-0.6	-0.6	-0.7	-0.7
Medicare Secondary Payer	0	0	0	0	-1.2	-1.8	-1.9	-2.0	-2.2	-2.3
9 Other New Benefits										
Preventive Benefits	0	0	0	0.4	0.5	0.8	0.7	0.7	0.8	0.8
Other (Well Baby, Family Planning, Mental Health, Chiropractic Services, EACH/RPCH, IHS, FQHCs)	a	a	0.1	0.1	0.2	0.2	0.2	0.2	0.2	0.3
10 Graduate Medical Education Specialty Weighting	0	a	a	a	a	a	-0.1	-0.1	-0.1	-0.1
11 Bonus Payments in Health Professional Shortage Areas	0	0	0	0.1	0.2	0.2	0.2	0.2	0.2	0.2
12 Part B Premium Offsets	0	0.3	0.8	1.6	1.9	2.0	2.1	2.1	2.3	2.4
13 Effect of Growth Limits b/	0	-2.7	-7.4	-14.5	-24.5	-35.2	-48.0	-63.5	-81.9	-103.6
Total Medicare Parts A and B	a	-3.1	-7.5	-10.9	-17.9	-30.6	-43.2	-56.4	-75.7	-96.5
Medicare Part C										
14 Program Outlays	0	0	0	0	78.5	142.0	175.7	211.7	249.1	273.4
15 Additional Costs of the Disabled	0	0	0	0	5.3	8.4	10.0	11.7	13.8	15.9
Total Medicare Part C	0	0	0	0	83.8	150.4	185.7	223.4	262.9	289.3
Low-Income Assistance										
Premium Subsidies:										
16 For Medicare Beneficiaries Below 120 Percent of Poverty (Replaces premium payments by Medicaid for QMBs)	0	0	0	0	4.6	6.3	6.6	6.9	7.2	7.6
17 For Persons Between 0 and 240 Percent of Poverty	0	0	0	0	82.7	117.6	127.4	140.4	152.0	166.4
18 For Retirees Between 0 and 240 Percent of Poverty	0	0	1.0	1.4	1.6	1.8	2.0	1.7	1.1	0.2
19 Employer Subsidies for Retirees	0	0	0	0	1.8	2.3	1.9	1.5	0.9	0.2

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(By fiscal year, in billions of dollars)

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
<i>Cost-Sharing Subsidies:</i>										
20 For Medicare Beneficiaries Below Poverty	0	0	0	0	9.1	12.7	13.5	14.5	15.4	16.1
21 For Certain Low-Income Beneficiaries	0	0	0	0	18.7	26.7	28.8	31.1	33.2	35.4
22 Low-Income Wraparound Benefits	0	0	0	0	8.4	12.1	13.1	14.1	15.2	16.4
Total - Low-Income Assistance	0	0	1.0	1.4	126.8	179.5	193.4	210.1	225.0	242.2
<i>Public Health Initiatives</i>										
23 Biomedical Research	0	0.1	0.4	0.5	0.6	0.6	0.6	0.7	0.7	0.7
24 Core Functions	0	0.2	0.5	0.7	0.7	0.7	0.8	0.8	0.9	0.9
25 Federally Qualified Health Centers	0	0.6	1.3	1.7	1.7	1.8	1.8	1.9	1.9	1.9
26 National Health Service Corps	0.1	0.2	0.2	0.2	0.3	0.3	0.3	0.3	0.4	0.4
27 Indian Health Service	0	0	0	0	2.8	3.7	3.9	4.1	4.3	4.5
28 Public Health Scholarships/Loan Repayments	0	0	0	0	a	a	a	a	a	a
29 Capital Financing Assistance	0	0.5	0.8	0.9	0.9	0.7	0.5	0.3	0.2	0.1
30 Academic Health Centers	0	1.5	2.3	2.4	2.6	2.6	2.9	2.9	3.2	3.3
Total - Public Health Initiatives	0.1	3.2	5.5	6.3	9.6	10.4	10.9	11.0	11.5	11.9
<i>Other Programs</i>										
31 Federal Employees Health Benefits	0	0	0.8	0.8	0.9	1.0	1.1	1.2	1.3	1.3
32 Department of Veterans Affairs	1.3	3.2	8.0	16.8	13.6	13.3	14.4	15.5	16.7	18.1
33 Social Security Benefit Effects	0	0	0.2	0.2	0.8	1.4	1.4	1.4	1.3	1.3
34 Long-Term Care Program	0	0	0	4.0	6.5	8.0	9.5	11.0	12.5	14.5
Total - Other Programs	1.3	3.2	9.0	21.8	21.8	23.8	26.4	29.2	31.8	35.1
TOTAL MANDATORY OUTLAY CHANGES	1.3	3.3	8.0	18.7	111.2	168.0	191.5	220.5	250.8	256.4
DISCRETIONARY OUTLAYS										
<i>Administrative and Start-Up Costs</i>										
35 Subsidy Administrative Costs	0	0	0.2	0.2	8.4	8.4	8.5	9.2	9.2	10.0
36 Administrative and Start-Up Costs	0	0.2	0.4	0.7	1.9	1.7	1.9	2.0	2.2	2.2
Total - Administrative and Start-Up Costs	0	0.2	0.6	0.9	10.2	10.2	10.4	11.2	11.4	12.2
<i>Public Health Service</i>										
37 Public Health Service Programs	0.9	1.6	1.8	2.0	2.1	2.1	2.2	2.2	2.3	2.3
38 Public Health Service Offset Due to Universal Coverage	0	0	0	0	-1.7	-1.9	-1.9	-2.0	-2.0	-2.1
39 Indian Health Service Offset <i>of</i>	0	0	0	0	-1.7	-2.3	-2.4	-2.5	-2.6	-2.6
Total - Public Health Service	0.9	1.6	1.8	2.0	-1.3	-2.1	-2.2	-2.3	-2.3	-2.4

Table 1. Estimated Federal Budgetary Effects of Congressman Gephardt's Proposal
(By fiscal year, in billions of dollars)

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Other Programs										
40 Essential Access Community Hospitals Grants	0.9	0.9	0.9	0.9	0.9	0	0	0	0	0
41 Federal Employees Health Benefits	0	0	1.3	1.2	1.5	1.6	1.8	1.9	2.0	2.1
42 Department of Veterans Affairs c/	0	-2.1	-5.8	-15.0	-15.6	-16.2	-16.8	-17.5	-18.1	-18.8
43 Department of Defense	0	a	a	a	a	a	0	0	0	0
Total Other Programs	0.9	-1.2	-3.5	-13.0	-13.2	-14.6	-15.0	-15.5	-16.1	-16.7
TOTAL DISCRETIONARY OUTLAY CHANGES	1.8	0.6	-1.1	-10.1	-4.3	-6.5	-6.8	-6.6	-7.0	-7.0
TOTAL OUTLAY CHANGES	3.1	3.9	6.9	8.6	106.9	161.5	184.7	214.0	243.8	251.4
RECEIPTS										
44 Medicare Part C Premium Receipts	0	0	0	0	71.6	131.5	166.4	205.2	247.2	273.4
45 Net Medicare Part C Premium Payments from Nonenrolling Employers	0	0	0	0	29.7	42.3	39.2	33.0	28.0	6.7
46 Extend Medicare Coverage of, and Extend Phase-in of HI Tax to All State and Local Government Employees	0	0	0.3	0.7	1.0	1.3	1.4	1.3	1.2	1.2
47 Health Benefits May Not Be Provided Under Cafeteria Plans	1.4	3.0	4.6	5.3	4.7	4.9	5.7	6.6	7.5	8.4
48 Modification of COBRA Continuation Care Rules					----- Negligible Revenue Effect -----					
49 Limitation on Prepayment of Medical Expenses					----- Negligible Revenue Effect -----					
50 Treatment of Nonprofit Health Care Organizations					----- Negligible Revenue Effect -----					
51 Increase Reporting Penalties for Nonemployees	0	a	a	a	a	a	a	a	a	a
52 Tax Treatment of Accelerated Death Benefits Under Life Insurance Contracts	a	a	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1
53 Postretirement Medical and Life Insurance Reserves					----- Negligible Revenue Effect -----					
54 Increase in Tax on Tobacco Products	0.7	2.7	4.5	6.1	7.6	7.4	7.1	6.9	6.8	6.7
55 Grant Tax-Exempt Status to State Health Insurance Risk Pools	a	a	a	a	0	0	0	0	0	0
56 Allow Certain Insurers to Qualify for Section 833 Deduction					----- Negligible Revenue Loss -----					
57 2% Excise Tax on Private Health Insurance Premiums	0	4.0	6.3	6.9	8.8	9.9	10.3	10.8	11.3	12.3
58 Self-Employed Health Insurance Deduction	-0.5	-0.4	-0.5	-0.5	-1.2	-2.5	-2.7	-3.0	-3.2	-3.4
59 Two-Tiered Small Business Credit	0	0	0	0	-4.7	-7.4	-7.6	-7.8	-8.1	-6.5
60 Provide for Medical Savings Accounts					----- Negligible Revenue Effect -----					
61 Provide Credits to Medical Providers in Underserved Areas	0	a	a	a	a	a	a	a	a	a
62 Part B Premium Increase for High-Income Individuals	0	0	0	1.5	1.4	1.8	2.2	2.7	3.3	4.1
63 Income and Payroll Tax Effects	0	-0.6	-6.8	-9.6	-33.4	-46.5	-50.0	-53.1	-57.0	-58.3
TOTAL RECEIPT CHANGES	1.6	8.7	8.3	10.3	85.4	142.6	171.9	202.5	236.9	244.5

Table 1. Estimated Federal Budgetary Effects of Congressman Gephardt's Proposal

(By fiscal year, in billions of dollars)

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
DEFICIT										
CHANGES IN REVENUES AND MANDATORY SPENDING	-0.3	-5.4	-0.3	8.4	25.8	25.4	19.6	18.0	13.9	13.9
CUMULATIVE TOTAL	-0.3	-5.6	-5.9	2.5	28.3	53.7	73.2	91.3	105.2	119.0
TOTAL CHANGES <i>d/</i>	1.5	-4.8	-1.4	-1.7	21.5	18.9	12.8	11.5	6.9	6.9
CUMULATIVE TOTAL <i>d/</i>	1.5	-3.3	-4.7	-6.4	15.1	34.0	46.8	58.3	65.2	72.1
CHANGES IN REVENUES, MANDATORY SPENDING, AND DISCRETIONARY SPENDING LIMITS	-0.3	-7.5	-6.1	-6.6	8.5	6.8	0.4	-1.9	-6.8	-7.6
CUMULATIVE TOTAL	-0.3	-7.7	-13.8	-20.4	-12.0	-5.1	-4.8	-6.7	-13.5	-21.1

SOURCES: Congressional Budget Office; Joint Committee on Taxation.

- a. Less than \$50 million.
- b. The estimate assumes that the expenditure limits would be less than fully effective.
- c. The proposal would reduce the limits on discretionary spending to reflect these changes.
- d. Includes changes in discretionary spending that would not be counted for pay-as-you-go scoring under the Budget Enforcement Act.

Memorandum:

Change in Discretionary Spending Limits

Veterans Benefits	0	-2.1	-5.8	-15.0	-15.6	-16.2	-16.8	-17.5	-18.1	-18.8
Indian Health Service	0	0	0	0	-1.7	-2.3	-2.4	-2.5	-2.6	-2.6
Total	0	-2.1	-5.8	-15.0	-17.3	-18.5	-19.2	-20.0	-20.7	-21.5

Table 2. Estimated State and Local Budgetary Effects of Congressman Gephardt's Proposal
 (By fiscal year, in billions of dollars)

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
OUTLAYS										
<u>Medicaid</u>										
1 Discontinued Coverage of Acute Care	0	a	a	a	-38.8	-57.4	-64.3	-71.3	-79.5	-88.2
2 State Maintenance-of-Effort Payments	0	0	0	0	44.3	63.3	67.8	69.7	66.7	71.4
3 Administrative Savings	0	0	0	0	-0.4	-0.6	-0.7	-0.8	-0.8	-0.8
Total - Medicaid	0	a	a	a	5.1	5.3	2.8	-2.4	-13.6	-17.6
<u>Public Health Initiatives and Administrative Expenses</u>										
4 PHS State and Local Matching Funds	a	1.1	2.1	2.7	2.9	2.9	2.8	2.8	2.7	2.7
5 General Administrative and Start-Up Costs	0	0.4	0.4	0.5	0.5	0.5	0.6	0.6	0.6	0.7
Total - Public Health and Administrative Expenses	a	1.5	2.6	3.2	3.4	3.4	3.4	3.4	3.3	3.4
Total State and Local Outlay Changes	a	1.5	2.6	3.2	8.5	8.7	6.2	1.0	-10.3	-14.2

SOURCE: Congressional Budget Office.

**Table 3. Projections of National Health Expenditures Under Congressman Gephardt's Proposal
(By calendar year, in billions of dollars)**

	1997	1998	1999	2000	2001	2002	2003	2004
Baseline	1,263	1,372	1,488	1,613	1,748	1,894	2,052	2,220
Proposal	1,281	1,387	1,605	1,701	1,827	1,959	2,097	2,258
Change from Baseline	18	16	117	88	78	65	45	37

SOURCE: Congressional Budget Office.
