

Financial Impact of the Proposal

The Managed Competition Act aims to slow the growth of national health expenditures and increase the number of people with health insurance. In the Congressional Budget Office's (CBO's) estimation, the proposal would lead to a slight increase in national health expenditures in the near term but would reduce health spending in the long run. Under the proposal, more than 15 million additional people would be covered by health insurance, and the number of uninsured would fall to less than 10 percent of the population.

The Managed Competition Act would achieve these outcomes by fundamentally transforming the nation's health insurance markets and its health care delivery system. The effects of these changes, however, are difficult to predict. Like the estimates of other proposals for comprehensive reform, such as the Administration's proposal or the single-payer plans, CBO's estimates of the effects of the Managed Competition Act are unavoidably uncertain.¹ Despite their lack of precision, however, estimates of the effect of different approaches to health reform provide useful comparative information on their relative costs or savings.

CBO's estimates of the effects of the Managed Competition Act on national health expenditures and the federal budget use CBO's baseline projections as their starting point. *The Economic and Budget Outlook: Fiscal Years 1995-1999* (January 1994)

1. CBO has released estimates of the costs of the Administration's proposal (H.R. 3600) and two single-payer plans (H.R. 1200 and S. 491) and will soon be providing estimates for other pending proposals. See Congressional Budget Office, *An Analysis of the Administration's Health Proposal* (February 1994).

describes CBO's current economic assumptions and baseline budget projections. A CBO Memorandum, "Projections of National Health Expenditures: 1993 Update" (October 1993), sets out CBO's baseline projections of national health expenditures.

Determining the Standard Benefit Package

The Managed Competition Act poses a major problem for estimation because it does not specify one of the most crucial elements of the new system--the standard benefit package that would be offered by accountable health plans (AHPs). Over the 10 years covered by CBO's estimate, a more comprehensive package would add to budgetary costs and national health expenditures. With a comprehensive standard benefit package, people would have little need to purchase supplementary health insurance coverage, but the demand for such supplementary coverage could be considerable if the standard package was very limited.

Under the proposal, the Health Care Standards Commission would specify the standard benefit package. This package would go into effect unless disapproved by a joint resolution of the Congress, which would have to be signed by the President. The commission could change the benefit package annually under the same procedure.

One can only speculate about the comprehensiveness of the benefit package that the commission might choose. As a politically appointed body, the

commission would be subject to many pressures, including the need to obtain Congressional and Presidential approval for its recommendations. It might find it difficult to limit the services that would be covered under the standard package. If so, the benefits could be fairly comprehensive--for example, somewhat more generous than the average of existing private health insurance policies--and the package would be relatively costly. Alternatively, the commission could try to design a benefit package whose cost did not exceed the savings generated by the proposal. Such a limited package, however, would be far less comprehensive than the benefits now enjoyed by the vast majority of people with health insurance.

Because of the uncertainty regarding the benefit package, CBO has estimated the financial impacts of the proposal using two illustrative alternatives--a comprehensive benefit package, which is identical to that proposed by the Administration, and a limited benefit package, which is 20 percent less costly. For differing reasons, however, neither of these two alternatives is likely to be workable without further adjustments to the proposal.

Alternative 1: A Comprehensive Benefit Package

The first benefit package--a relatively comprehensive one--would cover the same services in the first year as the package specified in the Administration's health proposal. This package is roughly 5 percent more generous than the average private health insurance plan, but a bit less generous than the average plan provided by large firms.

The explicit limits on the growth of health insurance premiums included in the Administration's proposal but absent in the Managed Competition Act complicate the comparison of the benefit packages in the two proposals after the first year. Ultimately, the Administration's proposal would limit the growth of premiums to roughly the rate of growth of the economy. The rate of growth of premiums under the Managed Competition Act, which would rely primarily on market forces to constrain costs, would be higher. Whether the Administration's proposal could actually provide the

same level of health benefits and services as the Managed Competition Act with a much lower level of spending is not clear. To some extent, the Administration's proposal might constrain costs by reducing inefficiencies or limiting payments to providers of health care. But it is also possible that the Administration's proposal would result in a lower amount or quality of health care services than the Managed Competition Act, even if the benefit packages in the two proposals were nominally the same.

Under the comprehensive alternative, the subsidies and other costs to the federal government would far exceed the savings generated by the proposal. Because the proposal would largely preclude increases in the deficit, other steps would have to be taken to make up the shortfall. If the Congress did not adopt additional spending cuts or tax increases, the commission would be required to reduce the premium subsidies provided to accountable health plans for low-income participants. In that case, AHPs would have to accept the reduced subsidies as full payment and would have to find ways to deal with the shortfall. As Chapter 5 describes in detail, however, CBO believes that the uncertainty and instability inherent in this process could seriously compromise the orderly functioning of the market for accountable health plans.

Alternative 2: A Limited Benefit Package

The second illustrative option is a much more limited standard benefit package. This package is 20 percent less expensive than the comprehensive one and would roughly balance the savings and costs of the proposal over its first five years of operation. Equating the costs and savings each year would require annual changes in the benefit package, both up and down, and would create serious administrative problems for consumers, health plans, and health plan purchasing cooperatives (HPPCs). The benefit package that could be obtained for this lower premium would be less generous than that enjoyed by 90 percent of people with private health insurance coverage. Such a benefit package would not cover mental health services, prescription drugs, preventive health services, or dental care and would

severely limit coverage of hospitalization. In addition, CBO has assumed that this alternative would not provide cost-sharing subsidies to people with incomes above 100 percent of the poverty level.

The second alternative is as problematic as the first, although for different reasons. First, the limited benefit package assumed by CBO may not be consistent with the proposal's requirement that the benefit package cover all medically appropriate treatments and a full range of preventive and diagnostic services. Second, in order to make the proposal fit within the available funds, CBO has eliminated the cost-sharing subsidies that the proposal specified for persons with incomes between the poverty level and twice the poverty level.

Under the limited alternative, those with income below 100 percent of poverty would continue to have rather generous coverage: the wraparound benefit would cover the excluded services, and they would be required to pay only nominal cost sharing. Those with incomes not far above the poverty level, however, would have less comprehensive benefits and would have to pay significant amounts of cost sharing from after-tax income. Under the proposal, they could not obtain supplementary policies that covered this cost sharing. Among upper-income people, supplementary insurance covering the excluded services and bought with after-tax dollars could become widespread. Thus, under this alternative, health insurance coverage would probably be more limited for middle-income people than for the rich or poor.

Estimating Health Insurance Premiums

A second critical element in assessing the impact of the Managed Competition Act is estimating the premiums that would be charged for accountable health plans inside and outside the HPPCs. This section describes how CBO estimated the initial level of premiums for the comprehensive benefit package and their subsequent rate of growth. The premiums for the limited benefit package were assumed to be 20 percent lower across the board.

Initial Level of Premiums

The premiums to be paid to health insurance plans and the extent of health insurance coverage under the proposal must be estimated jointly. For a given set of benefits, the level of the premium, net of any government subsidy or employer contribution, affects the number of people who buy insurance, and the number of people who buy insurance affects the premium.

The estimate proceeds in three steps: calculate the amount of health spending under the proposal for people who would be eligible to participate in the HPPC and for those who would have to purchase their AHP through their employer, estimate the proportion of people in various demographic categories who would decide to purchase health insurance, and compute the average premiums inside and outside the HPPC based on the amount of health spending for those who would choose to participate in the program.

The estimate of premiums relies on demographic and income data from the March 1993 Current Population Survey (CPS) and data on the use of health care services from the 1987 National Medical Expenditure Survey. The population was subdivided into categories based on the proposed premium classes (individual, individual and spouse, individual and one child, and individual and family), current insurance coverage (employer-sponsored insurance, individually purchased insurance, Medicaid, or no insurance), level of income, size of the primary worker's firm, and whether or not the employer now contributes to the cost of insurance. The data on use of health care services were used to allocate national health expenditures among each category of people. The expenditure figures were boosted to reflect the higher use of services expected for those becoming newly insured, the generosity of the comprehensive benefit package, and an increase in rates of payment for services previously paid by Medicaid.

All people who currently receive cash welfare benefits, purchase individual health insurance, or work for large employers that provide health insurance were assumed to purchase health insurance coverage under the new system. As discussed in

Chapter 4, however, enacting the proposal is likely to cause some employers to reduce their contributions to their employees' health insurance and allow the government to assume the cost of covering their low-income workers. The estimate assumes that 10 percent of workers with employer-sponsored insurance in small firms would lose their employer's contribution and that half of these workers would still decide to purchase insurance. In addition, for workers with incomes below the poverty level, the average payment by contributing employers was assumed to fall from about 85 percent of the cost initially to about 75 percent over 10 years, since some employers would cease making contributions for low-income workers. For the rest of the population--primarily the uninsured and Medicaid recipients who do not receive cash welfare benefits--the decision to purchase or not purchase health insurance was assumed to hinge on its net price.² The participation rates for low-income people, who would see large reductions in the net price of insurance, was assumed to depend on the ratio of price to household income.³

The estimated average premiums in 1994 for the comprehensive benefit package for the four types of policies specified in the proposal are as follows:

	<u>Inside HPPC</u>	<u>Outside HPPC</u>
Individual	\$2,500	\$2,345
Individual and Spouse	\$5,000	\$4,690
Individual and One Child	\$3,976	\$3,560
Individual and Family	\$6,796	\$6,153

Based on data on the distribution of insurance premiums, the estimate assumes that the reference premium--the premium for the least expensive plan in the HPPC with substantial enrollment--would be 90 percent of the premium of the average plan.

2. Congressional Budget Office, "Behavioral Assumptions for Estimating the Effects of Health Care Proposals," CBO Memorandum (November 1993), pp. 4-5.

3. Lewin-ICF, Inc., "Insurance Coverage and Health Expenditures Under the Bush and Clinton Health Reform Plans" (October 1992), p. 12.

The premiums inside the HPPCs would exceed those outside the HPPCs by about 10 percent because of differences in the use of health care services by the insured population. In particular, the HPPCs would cover most current recipients of Medicaid as well as many early retirees, both of whom are relatively heavy users of health care. Congressman Jim Cooper has informed CBO that he intends to modify his proposal by placing disabled Medicaid beneficiaries in a separate risk pool. This change could reduce the difference in premiums between plans in HPPCs and those outside by as much as one-half.

Although the comprehensive benefit package in the Managed Competition Act is assumed to be the same as the standard package in the Administration's proposal, the cost of the package would differ. For example, the 1994 premium for a single person would be an estimated \$2,100 under the Administration's proposal and almost \$2,400 for all AHPs (both inside and outside HPPCs) under the Managed Competition Act. About \$50 of this difference stems from treatment of Medicaid beneficiaries, whose costs would be largely excluded from the premium calculation for the Administration's plan. The generous cost-sharing subsidies--which would increase the use of health care services by low-income enrollees--and the assumed increase in Medicaid's payment rates add another \$100 to the premium for the Managed Competition Act. The remaining difference is largely attributable to adverse selection; the Administration's proposal would require universal participation, but low-risk individuals could opt to go without insurance under the Managed Competition Act.

Rate of Growth of Premiums

The estimate assumes that the proposal would slow the rate of growth of health expenditures and health insurance premiums for two reasons. First, the proposal would encourage more people to enroll in health maintenance organizations (HMOs). Second, the competitive pressures created by managed competition would cause all insurers to intensify their efforts to control costs.

Because group- or staff-model HMOs can provide health care more efficiently than other organizational forms, they would probably be the lowest bidders in most HPPC areas. Thus, the proposal would increase the difference in effective prices between fee-for-service plans and HMOs because people would have to pay the higher cost of fee-for-service plans out of after-tax rather than before-tax income. Based on the experience of California, Minnesota, and Wisconsin--states whose health insurance programs for public employees embody aspects of managed competition--CBO assumes that three-quarters of the nonpoor, urban population would ultimately choose HMOs instead of more expensive fee-for-service plans. Based on its review of the available evidence, CBO finds that the most effective HMOs reduce the use of health care services by about 9 percent compared with the fee-for-service sector and that the average reduction is about 4 percent.⁴ All in all, the estimate assumes that the shift to managed care would slow the growth in costs for private health plans by 0.6 percentage point per year for the first five years of the proposal. This assumption presumes that HMOs would find some way to cope with the difficulties created for them by the cost-sharing requirements and the limited benefit package (see Chapter 5).

As detailed in Chapter 2, the proposal incorporates, to some degree, all of the features important to the success of managed competition in controlling health care costs, except universal health insurance coverage. Because managed competition is an untried concept, however, no data exist that would allow one to estimate its effect on the growth of health expenditures. In the absence of any data, this estimate assumes that the system of managed competition established by the proposal would dampen the rate of growth of private health insurance costs by an amount reaching 1 percentage point a year after 2004. The same assumption about the effect of managed competition is used for both alternatives--the comprehensive and the limited benefit packages--although managed competition would affect a smaller share of health spending if the standard package was limited in its scope.

4. Congressional Budget Office, "Effects of Managed Care: An Update," CBO Memorandum (March 1994).

How the Proposal Would Affect Health Insurance Coverage and National Health Expenditures

The Managed Competition Act would encourage more people to obtain health insurance coverage by subsidizing its purchase. People with very low incomes would receive direct government subsidies, and people with higher incomes would be allowed to deduct the cost of health insurance from their taxable income. At first, the expansion of health insurance coverage would increase the demand for health care services and would add to national health expenditures. In the longer run, however, the system of managed competition would slow the growth of health spending and bring national health expenditures below the baseline level.

The estimates of health insurance coverage and national health expenditures assume that the premium assistance specified in the proposal is fully funded, either through additional spending cuts, tax increases, or borrowing. Failure to fund the subsidies could result in an upward spiral of health insurance premiums, declines in health insurance coverage, and, potentially, the collapse of the HPPC system (see Chapter 5).

Health Insurance Coverage

The low-income assistance and tax subsidies contained in the proposal would induce 18 million of the uninsured in 1996 to purchase health insurance. More than 2 million people who would be eligible for Medicaid under current law, however, would have their health insurance only partly subsidized and would choose not to obtain coverage. Another 1 million people now covered by small employers would drop coverage after their employer ceased to contribute to the cost of their plan. The net increase in health insurance coverage would be 15 million people (see Table 3-1). Most of the increase in coverage--11 million people--would occur for people in poor families, whose purchase of insurance would be fully subsidized.

The proposal would leave 24 million people uninsured. About 4 million poor people are assumed not to participate in the program despite the availability of a full subsidy--a rate similar to that for other public benefit programs. In addition, the cost of insurance would continue to deter some 16 million people with family incomes between 100 percent and 300 percent of the poverty level from participating. For nonelderly people with incomes over 300 percent of poverty, the rate of coverage would exceed 96 percent. In all, the proportion of

the population without coverage would drop from an estimated 15 percent in 1995 to 9 percent in 1996 and remain roughly the same thereafter.

Insurance coverage would be similar with both the comprehensive and the limited benefit packages. Although the premiums for the limited package would be 20 percent lower than for the comprehensive package, the benefits would be 20 percent less, and the effective price of insurance would be little changed.

Table 3-1.
Health Insurance Coverage Under the Managed Competition Act (By calendar year, in millions of people)

	1996	1997	1998	1999	2000	2001	2002	2003	2004
Baseline									
Insured	222	224	226	228	229	230	232	233	234
Uninsured	<u>39</u>	<u>40</u>	<u>40</u>	<u>40</u>	<u>41</u>	<u>42</u>	<u>43</u>	<u>43</u>	<u>44</u>
Total	261	264	266	268	270	272	274	276	278
Uninsured as Percentage of Total	15	15	15	15	15	15	16	16	16
Alternative 1: Comprehensive Benefit Package									
Insured	237	239	242	243	245	247	249	251	253
Uninsured	<u>24</u>	<u>24</u>	<u>24</u>	<u>25</u>	<u>25</u>	<u>25</u>	<u>25</u>	<u>26</u>	<u>26</u>
Total	261	264	266	268	270	272	274	276	278
Increase in Insured	15	15	16	16	16	17	17	18	18
Uninsured as Percentage of Total	9	9	9	9	9	9	9	9	9
Alternative 2: Limited Benefit Package									
Insured	237	240	242	244	246	247	249	251	253
Uninsured	<u>24</u>	<u>24</u>	<u>24</u>	<u>24</u>	<u>25</u>	<u>25</u>	<u>25</u>	<u>25</u>	<u>25</u>
Total	261	264	266	268	270	272	274	276	278
Increase in Insured	15	16	16	16	16	17	18	18	19
Uninsured as Percentage of Total	9	9	9	9	9	9	9	9	9

SOURCE: Congressional Budget Office.

NOTE: The estimates assume full funding of the subsidies.

Table 3-2.
Projections of National Health Expenditures Under the Managed Competition Act
(By calendar year, in billions of dollars)

	1996	1997	1998	1999	2000	2001	2002	2003	2004
Baseline									
Total	1,163	1,263	1,372	1,488	1,613	1,748	1,894	2,052	2,220
Alternative 1: Comprehensive Benefit Package									
Total	1,196	1,288	1,392	1,495	1,610	1,750	1,888	2,035	2,190
Change from Baseline	33	25	20	7	-3	2	-6	-17	-30
Alternative 2: Limited Benefit Package									
Total	1,178	1,271	1,375	1,480	1,597	1,726	1,865	2,013	2,171
Change from Baseline	15	8	4	-8	-16	-23	-30	-39	-50

SOURCE: Congressional Budget Office.

NOTE: The estimates assume full funding of the subsidies.

National Health Expenditures

The proposal would make health insurance available to a much larger group than is currently covered, which would initially increase national health expenditures. The estimate assumes that the newly insured would increase their use of covered health services by 57 percent.⁵ It also assumes that the comprehensive benefit package would initially be about 5 percent more expensive than the average benefit of privately insured people in the baseline. In 1996, the increase in national health expenditures would amount to some \$30 billion for the comprehensive benefit package and half that amount for the limited benefit package (see Table 3-2).

The institution of managed competition, the shift to HMOs, and the cuts in Medicare would slow the growth of health spending and would even-

tually bring national health expenditures below the baseline. With the comprehensive benefit package, CBO projects that total spending on health in 2004 would be \$30 billion below what it would be if current policies and trends continued. With the limited benefit package, health spending in 2004 would be \$50 billion--or 2 percent--below the baseline.

How the Proposal Would Affect the Budget

The Managed Competition Act would create a program of federal subsidies to help low-income people purchase health insurance and meet its cost-sharing requirements. It would also allow taxpayers to deduct in full spending for health insurance premiums (up to the reference premium rate) from income for tax purposes. These new federal costs would be financed primarily by repealing Medicaid and achieving savings in Medicare. In addition, by reducing

5. CBO, "Behavioral Assumptions," p. 21.

Table 3-3.
Estimated Budgetary Effects of the Managed Competition Act (By fiscal year, in billions of dollars)

	1996	1997	1998	1999	2000	2001	2002	2003	2004
Alternative 1: Comprehensive Benefit Package									
<i>Outlays</i>									
Premium Assistance									
Non-Medicare	68	97	105	113	122	134	145	157	168
Medicare	<u>3</u>	<u>4</u>	<u>5</u>	<u>5</u>	<u>5</u>	<u>6</u>	<u>6</u>	<u>6</u>	<u>6</u>
Subtotal	71	101	109	118	127	139	151	163	175
Cost-Sharing Assistance ^a									
Non-Medicare	29	41	45	48	52	57	62	67	71
Medicare	<u>9</u>	<u>15</u>	<u>17</u>	<u>18</u>	<u>20</u>	<u>23</u>	<u>25</u>	<u>28</u>	<u>31</u>
Subtotal	38	56	61	67	72	80	87	94	102
Repeal of Medicaid	-81	-121	-135	-151	-168	-186	-206	-227	-250
Medicare Savings	-1	-6	-9	-13	-17	-18	-19	-21	-23
Assistance for Long-Term Care	1	1	1	b	0	0	0	0	0
Medical Education	a	3	3	3	3	3	3	3	3
Postal Service Retirement	-2	-2	-3	-3	-3	-3	-3	-3	-3
Federal Administrative Costs	8	10	10	11	11	11	12	12	12
Other Spending	<u>b</u>	<u>1</u>	<u>b</u>						
Total, Outlays	35	42	38	32	26	26	24	21	16
<i>Revenues</i>									
Deduction of Health Insurance Premiums	-6	-15	-16	-17	-18	-20	-23	-24	-25
Increase in Medicare Premium for High-Income Individuals	1	1	2	2	2	3	4	5	7
Income and Payroll Taxes on Additional Income	3	5	5	6	6	6	6	6	6
Assessment for Medical Education	4	5	5	6	6	7	7	8	9
Excise Tax and Other	<u>b</u>	<u>-1</u>	<u>b</u>	<u>-1</u>	<u>-1</u>	<u>-1</u>	<u>-1</u>	<u>-1</u>	<u>-1</u>
Total, Revenues	1	-4	-4	-4	-4	-6	-7	-6	-6
<i>Deficit</i>									
Deficit with Full Amount of Subsidies	35	46	42	36	30	32	31	27	22
Shortfall in Subsidies	-30	-42	-38	-33	-28	-39	-50	-59	-68
Net Deficit Effect	5	4	4	3	3	-8	-19	-32	-46

SOURCES: Congressional Budget Office; Joint Committee on Taxation.

NOTES: The figures in the table include changes in authorizations of appropriations and in Social Security that would not be counted for pay-as-you-go scoring under the Budget Enforcement Act of 1990. The table excludes the effects of sections 1421 and 1422, which relate to rural emergency access care hospitals.

Table 3-3.
Continued

	1996	1997	1998	1999	2000	2001	2002	2003	2004
Alternative 2: Limited Benefit Package									
<i>Outlays</i>									
Premium Assistance									
Non-Medicare	54	77	83	90	97	105	113	122	131
Medicare	<u>3</u>	<u>4</u>	<u>5</u>	<u>5</u>	<u>5</u>	<u>6</u>	<u>6</u>	<u>6</u>	<u>6</u>
Subtotal	57	81	88	95	102	111	119	128	138
Cost-Sharing Assistance ^a									
Non-Medicare	30	42	45	49	53	57	61	66	71
Medicare	<u>9</u>	<u>15</u>	<u>17</u>	<u>18</u>	<u>20</u>	<u>23</u>	<u>25</u>	<u>28</u>	<u>31</u>
Subtotal	39	57	62	67	73	80	87	94	102
Repeal of Medicaid	-81	-121	-135	-151	-168	-186	-206	-227	-250
Medicare Savings	-1	-6	-9	-13	-17	-18	-19	-21	-23
Assistance for Long-Term Care	1	1	1	b	0	0	0	0	0
Medical Education	a	3	3	3	3	3	3	3	3
Postal Service Retirement	-2	-2	-3	-3	-3	-3	-3	-3	-3
Federal Administrative Costs	8	10	10	11	11	11	12	12	12
Other Spending	<u>b</u>	<u>1</u>	<u>b</u>						
Total, Outlays	22	23	17	10	2	-3	-8	-14	-21
<i>Revenues</i>									
Deduction of Health Insurance Premiums	-3	-7	-8	-9	-9	-11	-13	-13	-14
Increase in Medicare Premium for High-Income Individuals	1	1	2	2	2	3	4	5	7
Income and Payroll Taxes on Additional Income	5	7	7	8	8	8	8	8	9
Assessment for Medical Education	3	4	4	5	5	5	6	6	7
Excise Tax and Other	<u>3</u>	<u>5</u>	<u>6</u>	<u>7</u>	<u>7</u>	<u>7</u>	<u>8</u>	<u>8</u>	<u>9</u>
Total, Revenues	8	10	11	12	14	13	13	15	17
<i>Deficit</i>									
Deficit with Full Amount of Subsidies	14	14	6	-3	-11	-16	-21	-29	-39
Shortfall in Subsidies	-8	-8	-1	0	0	0	0	-1	-6
Net Deficit Effect	6	5	5	-3	-11	-16	-21	-31	-45

a. Includes wraparound benefit.

b. Less than \$500 million.

the growth of health spending, the proposal would reduce spending by employers for health insurance, raise earnings or other taxable income by a similar amount, and increase collection of income and payroll taxes. With the limited benefit package, the savings in the proposal would nearly equal its costs in the early years, and the savings would exceed the costs in 1999 and beyond. With the comprehensive benefit package, however, the savings would fall far short of covering the costs, and the proposal would require scaling back premium subsidies for the non-Medicare population by amounts ranging up to 45 percent.

Budgetary Treatment

The Managed Competition Act raises no knotty issues of budgetary treatment or classification. Unlike the Administration's health proposal, the Managed Competition Act would create no universal federal entitlement to health insurance. Participation would be voluntary. Also, unlike the health alliances in the Administration's plan, the HPPCs would have no authority to assess mandatory premiums. Therefore, although the HPPCs would be established under the terms of a federal statute, they would not exercise sovereign power, and their transactions should not be included in the accounts of the federal government. The budget would include, however, the taxes and spending items that would flow through the Treasury--for example, premium and cost-sharing assistance, federal administrative costs, and the changes to existing programs. Depending on how the system was structured, the redistribution of shortfalls in subsidies might also be considered a federal activity.

Subsidies

By far the largest cost of the proposal would be the premium and cost-sharing assistance for low-income people. Under the proposal, nonelderly persons with incomes up to 200 percent of the poverty level would be eligible for both types of subsidy. For Medicare beneficiaries, the premium assistance would extend to 120 percent of poverty, and cost-sharing subsidies would be provided to those with incomes below 100 percent of the poverty level.

CBO based its estimate of subsidies for non-elderly people on the March 1993 Current Population Survey. Using data from the CPS and the rules specified in the proposal, CBO assigned people to insurance units and categorized these units according to their premium class, demographic characteristics, and income bracket. The estimated amount of premium assistance for each category of unit depends on the reference premium for the class, the number of units, their average income, and the estimated rate of purchase of health insurance. Cost-sharing subsidies were assumed to equal 21 percent of the premium for the standard benefit package--a figure derived from the 1987 National Medical Expenditure Survey. The wraparound benefit was assumed to cost 9 percent of the standard premium. The estimated premium and cost-sharing assistance for Medicare beneficiaries are based on data for 1990 from the Health Care Financing Administration's Continuous Medicare History Sample.

With the comprehensive benefit package, premium assistance would total \$101 billion in fiscal year 1997--the first full year of the proposal--and \$175 billion in 2004 (see Table 3-3). Cost-sharing assistance (including both cost-sharing subsidies and the wraparound benefit) would grow from \$56 billion to \$102 billion over the same period. Over 60 percent of families insured through HPPCs and about 20 percent of families insured through other AHPs would receive some subsidy.

Premium assistance would be about 20 percent smaller with the limited benefit package than with the comprehensive one, but cost-sharing assistance would be about the same. To make the proposal roughly deficit neutral, the estimate eliminates cost-sharing subsidies for people with incomes above the poverty level. The additional cost of the wraparound benefit for people in poverty, however, would use up the savings generated by this change, so the total amount of cost-sharing assistance would be roughly the same for the two alternatives.

Other Outlays

The federal government would incur significant administrative costs to determine eligibility for

premium and cost-sharing assistance and to oversee the AHPs and HPPCs. In its first year of full operation, the Health Care Standards Commission would obligate almost \$10 billion and have outlays of more than \$8 billion. Processing applications for subsidies would require \$8.6 billion, assuming 43 million applications for assistance at a cost of \$200 per application. By comparison, it currently costs about \$160 to process an elderly person's claim for Supplemental Security Income and \$620 to process an application for Aid to Families with Dependent Children. The commission's other activities, primarily oversight of the health plans and HPPCs, would cost another \$1 billion.

Repeal of Medicaid would provide most of the funding for the proposal, totaling \$121 billion in 1997 and \$250 billion in 2004. In addition, the proposal would cut Medicare spending, primarily by slowing the growth of payments to hospitals and physicians, phasing out payments to disproportionate share hospitals, and changing the method of paying for medical education. CBO's estimates of the savings from these changes are consistent with the baseline projections of spending for the affected items.

The proposal would also make several smaller changes in federal spending. It would establish a temporary program of assistance for states that spend a very large share of their Medicaid funds on long-term care, create a new system for financing medical education, require the Postal Service to prefund health benefits for retirees, and expand several public health programs.

Revenues

The Joint Committee on Taxation (JCT) has estimated the impact of the provisions of the proposal that would affect income and payroll taxes. The major revenue-losing item is allowing full deductibility of health insurance premiums (up to the reference premium rate) from income for tax purposes. The revenue loss would reach \$25 billion in 2004 with the comprehensive benefit package, but only \$14 billion with the limited benefit package because the maximum allowable deduction would be less.

For the comprehensive benefit package, CBO and JCT assume that firms would largely avoid paying the 35 percent excise tax on excess health insurance premiums by limiting their contributions to the reference premium amount and returning the excess to workers primarily in the form of higher wages. Federal revenues would then rise because more compensation would be subject to both personal income and payroll taxation. If the commission adopted the limited benefit package, the tax cap would be lower, but many employees would want to obtain supplementary health insurance coverage. In this case, as explained in Chapter 2, workers could find it advantageous to have their employer pay for their supplementary policy--and pay the excise tax--rather than to receive that portion of their compensation as taxable earnings. Not all employers would take this tack, however, and the increase in income and payroll taxes would be slightly higher as a result of the lower tax cap.

Two other provisions of the proposal would also increase federal revenues. High-income individuals would be subject to an increase in their premiums for Medicare's Supplementary Medical Insurance. Also, each accountable health plan would be subject to an assessment of 1 percent of gross premium receipts to finance medical residency training.

Shortfall in Subsidies

The proposal would create a process to scale back premium assistance for low-income people not receiving Medicare if the proposed savings failed to cover the additional costs. With the comprehensive benefit package, the shortfall in subsidies would amount to about \$35 billion a year over the first five years. The required reduction in premium assistance for the non-Medicare population would range from almost 45 percent in 1996 to 23 percent in 2000. With the limited benefit package, the shortfall would amount to 15 percent in 1996, 10 percent in 1997, and little or nothing thereafter.

Despite the provision for limiting the amount of premium assistance, the proposal would add slightly to the deficit in the first few years, largely because the formula for computing the shortfall excludes federal administrative costs. With the limited bene-

fit package, the proposal would reduce the deficit in later years. The proposal could also reduce the deficit with the comprehensive benefit, but only because after 1999 it would not permit all the spending reductions to be counted against the cost of the subsidies. It would limit the growth of the countable savings in spending to the rate of growth

of gross domestic product, even though the actual savings would increase at a more rapid rate. If all the savings were made available to fund the subsidies, there would be no net deficit reduction, and the shortfall in funding the subsidies would be smaller.