S. HRG. 103–856

CBO ANALYSIS OF THE ADMINISTRATION'S HEALTH CARE REFORM PLAN

HEARING

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED THIRD CONGRESS

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CBO ANALYSIS OF THE ADMINISTRATION'S HEALTH CARE REFORM PLAN

WEDNESDAY, FEBRUARY 9, 1994

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:00 a.m., in room SD–215, Dirksen Senate Office Building, Hon. Daniel Patrick Moynihan (chairman of the committee) presiding.

Also present: Senators Baucus, Bradley, Mitchell, Pryor, Riegle, Rockefeller, Daschle, Breaux, Conrad, Packwood, Dole, Roth, Danforth, Chafee, Durenberger, Grassley, Hatch, and Wallop.

[The press release announcing the hearing follows:]

[Press Release No. H–6, February 2, 1994]

FINANCE COMMITTEE TO HEAR CBO ANALYSIS OF PRESIDENT'S HEALTH PLAN

WASHINGTON, DC—Senator Daniel Patrick Moynihan (D–NY), Chairman of the Senate Committee on Finance, announced today that the committee will continue its examination of health care issues with testimony from Congressional Budget Office Director Robert Reischauer regarding CBO's analysis of the administration's health care reform plan.

The hearing will begin at *10:00 a.m. on Wednesday, February 9, 1994* in room SD–215 of the Dirksen Senate Office Building.

"CBO's input is crucial in developing a non-partisan evaluation of the effects of the President's health plan on insurance coverage and costs, and the implications of the plan for the budget and the economy," Senator Moynihan said in announcing the hearing. "The committee looks forward to hearing from Director Reischauer on these most important issues."

OPENING STATEMENT OF HON. DANIEL PATRICK MOYNIHAN, A U.S. SENATOR FROM NEW YORK, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. A very good morning to our distinguished witness, Dr. Robert Reischauer, the Director of the Congressional Budget Office. This is the fourth in our series of hearings this year on the President's health care bill and such other bills as are about.

We decided, Senator Packwood and I, with the agreement of the committee we would go by topic rather than specific bill. Although it is the case today that we will be hearing from Dr. Reischauer on the analysis of the administration's health proposal which the CBO has prepared at our request, even so, the issues are general. We very much look forward to hearing what you have to say, Doctor. I hope you have set the morning aside because we will have questions for you.

Senator Packwood?

OPENING STATEMENT OF HON. BOB PACKWOOD, A U.S. SENATOR FROM OREGON

Senator PACKWOOD. Thank you, Mr. Chairman.

Congratulations, doctor, on your statement yesterday. But I congratulate you for a different reason. I am inclined to think this argument about taxes or not taxes perhaps is less than meets the eye.

If we pass a bill and we say to the employer or Mr. or Ms. Employer you shall provide the following health benefits—A, B, C, D, E, F, G—and you may buy it where you want from Continental Casualty or Blue Cross or Kaiser, and it costs $250 a month to that employer, it is $250 a month. And instead if we say you must buy it from the health alliance and it is $250 a month, it is still $250 a month whether you call it a tax or whether you do not call it a tax. It seems like it is money out of their pocket, which indeed it is.

I do not think we need the health alliances. I think we can do perfectly well having the employers or the individuals, if we do an individual mandate, purchase the insurance where they want and I think there will be ample competition among the providers.

But when Senator Dole said on the floor yesterday, and he was correct, if this money comes out of your pocket it may seem like a tax, but whether we call it that or not I am not sure is the critical issue, other than if indeed it goes to an immense government agency—and you correctly defined it yesterday, there is no question—and that is the tax, then the real issue ought to be not are we going to ask an individual to purchase health insurance or an employer to provide it or have the individual purchase it and have the employer pay part of it like Germany. That, I hope, is not the issue. I hope we are going to seek universal coverage.

In my mind the real issue is, are we going to attempt to administer this plan through the private sector or are we going to try to administer it through the government. I would hope we would opt for the former.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

We decided, if the committee recalls, that we will not have opening statements, but we will have lots of questions.

So, Dr. Reischauer, welcome, sir. You have a prepared statement. We will place that in the record and you may proceed exactly as you desire.

STATEMENT OF ROBERT D. REISCHAUER, PH.D., DIRECTOR, CONGRESSIONAL BUDGET OFFICE, WASHINGTON, DC

Dr. REISCHAUER. Mr. Chairman and members of the committee, I am pleased to have this opportunity to share with you the Congressional Budget Office's—CBO's—analysis of the administration's health reform proposal. I will submit my prepared statement for the record and confine myself to a summary of the report's major findings.

CBO's analysis deals with three aspects of the administration's proposal: First, its financial effects—that is, the likely impact of the proposal on national health expenditures in the Federal budget; second, the possible effects of the proposal on the nation's economy;

and third, the question of the appropriate budgetary treatment of the new system's fiscal flows.

Before summarizing CBO's major findings, I would like to emphasize three cautionary points that relate to the inevitable limitations of our analysis and, I might add, other similar analyses.

The first of these points is the great uncertainty that surrounds all estimates of the cost of this proposal and of all other systemic reform initiatives. The administration has put forward the most far-reaching piece of social legislation since President Franklin Roosevelt proposed the Social Security Act some 60 years ago. If the proposal is implemented as envisioned, the behavior of consumers and health care providers will be altered by new incentives. New institutions will be created, and old ones will be given significant new responsibilities. Available data and methodological techniques and our underlying knowledge of how the health system works are not adequate for estimating the effects of this legislation with a great deal of precision.

The second cautionary point that I must emphasize is that it will take some time before the full consequences of the proposed system play themselves out. The complete structure will not be in place for over a decade. For example, new dental and mental health benefits will begin in the year 2001. State and local governments will first be eligible for employer subsidies in 2002. The tax status of certain employer-provided premiums will change after 2003. Subsidies to large corporations that do not create corporate alliances will phase in over an 8-year period. A home- and community-based health care plan for the disabled will double in size between the years 2000 and 2004, and on and on. Furthermore, it will take many years for consumers and providers to respond fully to the new incentive structure.

For these reasons, your attention should focus on the long-term effects of the proposal. CBO's estimates extend to the year 2004, which is the latest year for which we have any capability to make an estimate. However, the farther into the future we project, the more uncertain our estimates are likely to be. And you should keep that in mind.

My third and final warning is that we need to keep all of the numbers in perspective. Some of the numbers will seem large when examined in isolation. But when compared with the size of the economy, the baseline level of national health expenditures, government spending on Medicare and Medicaid, and even the deficit, they may be relatively trivial.

With these cautions in mind, let me begin the discussion of the likely financial effects of the proposal. As you know, two of the major objectives of the administration's initiative are to slow the growth in national health expenditures and to reduce the relentless pressure that spending on the major health programs is placing on the Federal budget.

CBO estimates that if the administration's proposal is implemented according to its schedule, national health expenditures will rise by between 1 percent and 3 percent above our baseline projection levels during the period in which the alliance system is phased in. This is shown in Table 2–1 on page 26 of our report, if you happen to have the report handy. The increase is the inevitable con-

sequence of extending coverage to millions of uninsured Americans, increasing the generosity of the benefits that many currently insured Americans have, and expanding services for the disabled.

By the year 2000, the limits placed on the growth of premiums and the savings in the Medicare program are sufficient to reduce national health expenditures by some $30 billion below our baseline level. By the year 2004, national health expenditures should be $150 billion, or 7 percent below the baseline level. The budgetary impacts of the proposal, which I define here to include on-budget activities and Social Security, are shown in Table 2–2 on pages 28 and 29 of our report. The table represents the combined effort of the Congressional Budget Office and the Joint Committee on Taxation, which I would like to thank for their work under some pretty difficult circumstances.

Our estimates indicate that the proposal would reduce the fiscal year 1995 deficit by about $10 billion because the revenue from higher tobacco taxes would more than offset the first year's start-up costs.

The proposal would then increase annual deficits by between $1 billion and $32 billion during fiscal years 1996 to 2003. By 2004, CBO estimates that the proposal would have no appreciable affect on the deficit. If we had the ability to project further into the future, we would presumably see that the proposal would reduce the deficit by growing amounts after 2004.

CBO's deficit estimates are less sanguine than those of the administration or those prepared by the Virginia-based consulting firm Lewin-VHI in its excellent study of the administration's plan. On the one hand, both of those groups estimated that the proposal would lower cumulative deficits over the 1995–2000 period by modest amounts. CBO, on the other hand, shows a cumulative increase in deficits of $126 billion over the 1995–2004 period.

Some people might be tempted to exaggerate the importance of this difference, so let me place these numbers in their proper context. First, $126 billion is less than 6 percent of both the deficits accumulated over the past decade and the deficits that we project for the next 10 years. Second, $126 billion represents less than 3 percent of the projected Federal spending on Medicare and Medicaid during the next 10-year period. Third, the number should be balanced against the advantage of living in a nation in which no one lacks health insurance coverage. And finally, as I noted earlier, if the premium restraints are adhered to, the proposal should make ever-increasing contributions to deficit reduction after 2004.

Let me say a few words about the differences between the administration's and CBO's numbers. You can see from the last column in Table 2–4, which is on page 36 of our report, that the administration's and CBO's estimates of the proposal's net costs differ by $48 billion in the year 2000, which is the last year for which the administration has proposed an estimate.

Roughly half of that sum, or $25 billion, is attributable to CBO's higher estimate of employer subsidies. Our higher estimate of employer subsidies occurs because we believe that premiums will be about 15 percent higher than the administration has assumed and because we used a different estimating methodology, one that we

believe better accounts for the dispersion in average wages across firms.

As you can see from Table 2–4, there are no substantial differences between CBO's and the administration's estimates of family subsidies. There are modest differences in our estimates of the State maintenance-of-effort payments, the amounts that would be collected from assessments on corporate alliances, the increased revenues from restricting cafeteria plans, and the other components of the proposal taken together.

Let me turn now to the second topic, the proposal's likely economic effects. The administration's proposal would have important impacts on the economy. But for the most part, those impacts would not affect aggregate economic indicators as much as the circumstances facing different firms and different workers.

For example, the proposal would have little appreciable impact on the U.S. balance of trade, which is determined largely by the balance between national saving and investment. However, some firms in the tradable goods sector would benefit, while others would be adversely affected. Overall, businesses' costs for health insurance would be significantly reduced by the proposal. Businesses' insurance premiums for active workers would drop by about $90 billion below our baseline level in the year 2004.

But beneath this figure there would be considerable redistribution. On the one hand, universal coverage would mean that those firms that now offer insurance would no longer need to pay indirectly, through higher doctor's and hospital bills, for the care given to uninsured workers and their families. On the other hand, firms that do not now provide insurance could no longer "ride free." Community rating would mean that small firms and those with older or sicker work forces would see reductions in their costs, while businesses with young and relatively healthy workers might see their costs rise.

Changes in businesses' costs, both positive and negative, would be largely shifted back onto workers in the form of lower or higher wages. The impact of these changes on the aggregate labor supply is likely to be quite small, although the proposal's incentives could significantly affect the labor force participation decisions of certain types of workers.

For example, secondary workers and those for whom early retirement is an option could choose to leave the labor force voluntarily. Meanwhile, low-wage workers outside the health sector might see their job opportunities diminished. But CBO believes that the number of workers affected will be very small, and any adverse effects will be offset in part by low-wage job opportunities created in the health sector. Finally, some welfare recipients might be enticed into the labor force by the proposal's incentives.

Taking all of these labor market reactions together, CBO estimates that eventually between 0.25 percent and 1 percent of the labor force might prefer to stay home under the proposal. But I should add that CBO does not expect the proposal to have a significant impact on the unemployment rate.

CBO believes that the proposal would encourage firms and workers to reshuffle, so that low-wage workers would be largely grouped together in firms that received employer subsidies. This sorting

could impose efficiency costs if organizational structure was driven by the provisions of the administration's proposal rather than by the dictates of efficient production techniques.

Let me move on now to the final issue, which is the budgetary treatment of the administration's proposal. CBO strongly believes that ultimately this issue should be resolved by the Congress and the President through legislation. Nevertheless, CBO does have an advisory role to the budget committees on such matters, and we must assess the budgetary dimension of every piece of legislation for which we prepare a cost estimate.

Resolving the issue of budgetary treatment involves answering a series of questions. Is the program fundamentally governmental in nature, or does the legislation seek to facilitate, regulate, or guide an activity that remains essentially private? If the activity is primarily governmental, is it a Federal activity, a State activity, a shared State/Federal activity, or some new hybrid? If the answers to these first two questions point in the direction of a Federal governmental activity, one must decide how that activity should be displayed and controlled in the accounts of the Federal Government.

In trying to answer these questions, CBO has examined the details of the proposal very carefully. We have also turned to the two main sources of guidance on budgetary classification—namely, the 1967 report of the President's Commission on Budget Concepts and the current budgetary treatment of programs that are analogous to the administration's proposal.

We found that those two sources could inform our judgment but that they did not provide incontrovertible answers to the questions. After weighing all of the arguments, CBO has concluded that the proposed health alliances, as well as the various changes in on-budget activities, should be included in the consolidated accounts of the Federal Government.

Nonetheless, because of the uniqueness of the alliances and the vast size of their budgets, we suggest that they be displayed separately as is currently the practice for Social Security. Table 3–1 on page 50 of our report provides a suggested budgetary display.

CBO's assessment of this issue rests primarily on our judgment that the proposal would establish a universal entitlement to health insurance that would be largely financed by mandatory payments resulting from an exercise of sovereign power. Our view is also influenced by the specificity with which Federal laws and agencies would prescribe the actions of the alliances. In addition, we also believe that there is a need for fiscal accountability when an activity shares many financial flows with traditional on-budget accounts. Given that the alliances can be so characterized, this also suggests the importance of including them in the Federal Government's fiscal accounts.

Mr. Chairman, let me close by noting that some might use the information contained in our report in destructive, rather than constructive, ways. That would be tragic. Thanks to the courage and efforts of the President, we are once again trying to grapple with a serious national problem, one that Presidents from both parties—Harry Truman, Richard Nixon, Jimmy Carter, and George Bush—tried in vain to address. Each of them was stymied because the so-

lutions are so complex and because health reform unavoidably involves significant redistribution, a topic that our society does not like to deal with directly.

But we must remember two things: The problems inherent in the current health financing system will only grow worse if nothing is done, and the current system already contains huge amounts of redistribution, most of which is invisible and much of which is inequitable and distortionary.

It will not be easy to craft legislation that addresses these problems. It will take a good deal of political courage, a lot of hard work, and bipartisan cooperation. But it can be done. Whether the solutions this committee develops build on the framework proposed by the administration or on some other approach is not as important as that some substantial step forward be taken now that the President has created this opportunity. To that end, the Congressional Budget Office stands ready to work with this committee and its staff to develop those solutions.

Finally, I would like to thank you, Mr. Chairman, for the support you have given to the underlying principle behind the Congressional Budget Office, namely, that the analyses and estimates of this agency should be based solely on the staff's best analytical and professional judgment. Our report on the administration's health reform proposal reflects that principle. Thank you, and I will be glad to respond to any questions that you or the members might have.

The CHAIRMAN. Thank you, Doctor. You are very generous with those kind remarks.

[The prepared statement of Dr. Reischauer appears in the appendix.]

The CHAIRMAN. Let me respond, I think we all agree that you and your associates have performed everything we could have hoped for when the CBO was established back in the 1970's, in which I believe you and Alice Rivlin were among the principal founders, and here you are today.

The distinguished Republican leader is here. I wonder if he would not like to make an opening statement or some opening questions.

Senator DOLE. I would like to wait awhile.

The CHAIRMAN. You would like to wait awhile. All right. Good. Then we will just follow our regular routine.

Senator DOLE. Thank you.

The CHAIRMAN. I have just two questions of sorts. But first a clarifying point. I think you did clear this up when you referred to the sequence of Presidents who have made proposals in this area. On page 13 you say in your conclusion that the Health Security Act is unique among proposals to restructure the health care system, both because of its scope and its attention to detail.

You would not mind my saying that 20 years ago President Nixon proposed universal health care coverage with an employer mandate. So the scope is exactly what we have today and that, in fact, Senator Packwood introduced. You would agree with that?

Dr. REISCHAUER. Well, I have not gone back and looked over that piece of legislation.

The CHAIRMAN. Are you suggesting that we are a bunch of old fellows up here? [Laughter.]

Dr. REISCHAUER. No; rather people with better memories than I have.

The CHAIRMAN. Senator Packwood, it was universal coverage with a universal employer mandate.

Senator DOLE. No alliances.

The CHAIRMAN. No alliances. The point being, from my point of view, is simply to say, we have been at this for a long while. Twenty years ago, we had this measure before this committee and there comes a time when you probably ought to do something.

Now to the question of that very helpful final section in your report in which you talk about the—how do you call it—you call it simply other considerations.

Dr. REISCHAUER. Yes, other considerations. It is kind of catchy, is it not?

The CHAIRMAN. Well, it is a very fine statement. And in there, you write about unintended consequences, noting that "Policymakers and analysts can only speculate about such questions because of the magnitude of the institutional changes being proposed. The complexity and interrelated nature of the proposal's many components make it difficult to grasp all their possible interactions or to determine the extent of institutional change and development" and whether there might be unintended consequences that could affect the system's viability.

That term "unintended consequences," I am happy to report that Robert K. Murton, who first published that paper in 1935 is alive and well and spends his summers in East Hampton, NY. [Laughter.]

But one of the things that has puzzled me, and certainly beyond any analytic powers I have, is the fact that you referred to it in terms of the different premium caps for different sized firms.

There are altogether 6 different rates. They range from 3.5 percent for firms with fewer than 25 workers and an average wage below $12,000 per year up to the 7.9 percent. Six rates that apply to four firm size categories.

Dr. REISCHAUER. I do not think that should bother you. Over time, the importance of those special rates for small firms will diminish because the thresholds—the wage thresholds, $12,000 up to $24,000—are not indexed. So as wages grow, fewer and fewer firms will be affected.

In the long run—and I am not saying how long the long run is, maybe 40 years or so—no firm should be affected by the special rates. Instead, all firms will be subject to the single 7.9 percent-of-payroll cap.

The CHAIRMAN. You are a distinguished economist and you do recall, no matter what you say, you recall Lord Keyne's observation that in the long run we are all dead. [Laughter.]

Dr. REISCHAUER. With the advances of modern medicine, that might come into question.

The CHAIRMAN. That may be never. And you can anticipate Congress indexing those, can you not?

Dr. REISCHAUER. And I can also anticipate that we will give you a cost estimate when you try.

The CHAIRMAN. Fair enough. There are a lot of us here today. I just do think the effects on firms has got to be more than passing. I mean, would you not agree?

Dr. REISCHAUER. Yes, I would.

The CHAIRMAN. Thank you very much.

Senator Packwood?

Senator PACKWOOD. Last week, Doctor, we had six witnesses, pretty much across the spectrum, all of whom agreed that we could not get universal coverage without a mandate, including one of the witnesses that did not want universal coverage. They said if that is what you want you would have to mandate it. They said, you will not get there by incentives; you will not get there by tax credit; you will not get there by invitation, only by mandate. Do you agree with that?

Dr. REISCHAUER. Yes. I think you can get very close to it, but certainly not all the way there. For example, there are young people who feel that they are invincible and invulnerable, and others who just do not like to interact with organized society and who will stay out of a system.

The CHAIRMAN. Yes.

Senator PACKWOOD. If we were to mandate that individuals purchase this insurance as they do in Germany and employers share part of the cost, or if we mandate employees like we do worker's compensation in the States, and they purchased it privately wherever they wanted—would you then say that is not a tax and you would not score it as a tax?

Dr. REISCHAUER. First, let me say that the "T" word has not crossed my lips, nor will it.

Senator PACKWOOD. Would you score it the same way you would score the——

Dr. REISCHAUER. We would score the premium payments to the alliances as governmental receipts, and within the governmental receipts category there are lots of things besides taxes.

Senator DOLE. Name one.

Dr. REISCHAUER. I can go through dozens of them, ranging from patent and copyright fees to earnings of the Federal Reserve Board. But as I said yesterday, I do not want to make pronouncements on budgetary treatment without seeing legislative language. It is dangerous to one's health. I have learned that over the past few months.

But a more important thing that I would urge on this committee is to design a health care plan that makes sense, that effectively achieves the objectives you want to achieve, and not get all caught up in the budgetary treatment. You should not let budgetary treatment dictate program design.

If that had been the case back in the 1930's, can you imagine what we would have now in the way of a Social Security system? If we were considering the Medicare program today, we would probably be going through contortions to make sure that it was not counted as a governmental activity.

The fact of the matter is that some things that the Congress and the Nation want done are most effectively and efficiently done in a governmental way. Others perhaps are not. Design the program according to health objectives.

Senator PACKWOOD. I am on your side. [Laughter.]

All I want to know is——

Dr. REISCHAUER. There is nobody else.

Senator PACKWOOD [continuing]. How you would score it if we simply mandated it.

Dr. REISCHAUER. As I said, we would have to look at the legislative language. We go through a very complicated procedure in scoring, and I cannot simply say that if there is an employer mandate, that is automatically a governmental activity, or vice versa.

We have scored some proposals in the past as not being governmental activities that have had employer mandates in them. So it is possible.

Senator PACKWOOD. I can give you a good example from the States, although I have only checked two States, where they have worker's compensation and they allow a three-way system. The State can insure it and they have State industrial accident funds. You can self-insure or you can privately insure.

In those two States I checked, they only count as receipts the one that the State takes care of. If you purchase it from Aetna or you self-insure, the money never comes into the State and never goes out, and so they do not count it. Although it is a policy issue. You must provide worker's compensation.

I am assuming that would be roughly what we would do with health insurance. Even if you had an alliance but said you do not have to purchase it through the alliance if you do not want to. But if you did, that would probably count as a government receipt, even though it was voluntary but you chose to purchase it through the alliance. Would I be roughly correct in that assumption?

Dr. REISCHAUER. Those would certainly be some of the considerations that we would look at.

Senator PACKWOOD. The Chairman is the only person that I know that not only knows the laws but knows the author of the laws and calls them frequently. I remember when we were doing Social Security, he says, yes, Dr. Gulick, right?

The CHAIRMAN. Luther Gulick.

Senator PACKWOOD. He said, I just talked to him last week. He is a 100 years old, lives up on a farm. [Laughter.]

The CHAIRMAN. Pottsdam, NY.

Senator PACKWOOD. How much more did Dr. Gulick collect from Social Security than he paid in if he is a 100 now? [Laughter.]

The CHAIRMAN. I do not know but I can assure you that he would. [Laughter.]

He lived to be a 100.

Senator PACKWOOD. I have no other questions right now, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Packwood.

Senator Daschle?

Senator DASCHLE. Thank you, Mr. Chairman.

Dr. Reischauer, I think that your point is well taken. It is not how you cost something, but what it actually costs. That is really what it is you are trying to share with us today. I wonder how long it will be before we see a bumper sticker that we are now being charged as being a receipt and spend rather than a tax and spend Congress.

The primary objectives the administration has designed for this bill are to achieve universal coverage and cost containment by the end of the decade. I would really like you to address these particular goals. How close to the mark are we in accomplishing those two objectives under the current plan?

Dr. REISCHAUER. Well, as our report says, if the plan is implemented according to the legislative language, there will obviously be universal coverage. It will be successful in reaching that objective.

Moreover, the numbers that I provided for you on national health expenditures indicate that the administration's plan will slow down the rate of growth of national expenditures by a substantial amount. In fact, in my discussion with the Ways and Means Committee members yesterday, Mr. McDermott pointed out that the administration's proposal would have roughly the same slowdown effect that a single-payer plan would have—excuse me, his single payer plan.

Senator DASCHLE. He said it slows costs by a substantial amount while simultaneously providing universal coverage. I have not had a chance to look specifically at the numbers. How does one define substantial in this case?

Dr. REISCHAUER. The numbers I gave in my opening remarks would qualify. By the year 2004, national health expenditures in total would be around $150 billion, or 7 percent, below where they would otherwise be if we continued with the current system, according to our estimates.

Senator DASCHLE. That $150 billion is part savings to business and part savings to families; is that how it is broken down?

Dr. REISCHAUER. Yes.

Senator DASCHLE. You mentioned there is a $90 billion savings to business, which is a significant savings. Is that part of the $150 billion?

Dr. REISCHAUER. Yes, it would be.

Senator DASCHLE. I know you have not yet done careful analyses of each of the plans. Is it possible to achieve immediate savings under any one of the plans that is currently proposed? Isn't it likely you are going to see growth during this transition period in costs regardless of the plan that we may subscribe to?

Dr. REISCHAUER. One objective of virtually all of the plans is to expand coverage to those Americans who lack insurance coverage in its entirety or who have inadequate plans. In and of itself, meeting that objective would drive up costs.

At the same time, restraints would be put into place or incentives are created to hold down costs. It is very difficult to imagine a politically acccptable system in which the restraint could match the expenditure growth at the very beginning. So I think your assessment is an accurate one.

Senator DASCHLE. I would like you to elaborate a little bit more upon the impact on employment. There have been a lot of charges and countercharges about the affect of employment on the system and what the plan would do. You say the impact would be negligible. Could you describe what you mean by that?

Dr. REISCHAUER. Well, what we are saying is that the size of the labor force might diminish somewhat—by between 0.25 percent

and 1 percent point eventually in the long run, over 15 to 20 years. It will decline largely because some individuals will take advantage of the incentive to retire early—because they will get health insurance coverage as early retirees.

Usually, most often when somebody retires and leaves the labor force we do not regard it as an immense economic tragedy. We may be a little green with envy that they have the resources and ability to do so.

The fact that insurance will not be related to whether you work or not means that some secondary workers in families will choose not to participate in the labor force. They might be staying home to take care of children or to enjoy more leisure.

In part, their choosing not to participate would be a result of certain employer costs being shifted back onto workers in the form of lower wages in some firms. But once again, not participating is a voluntary decision, presumably the choice of individuals who feel themselves better off under the new incentive structure.

As I said, there could be some reduction in the number of individuals working at the minimum wage level, and this would come about because, of course, most of those workers do not receive health care benefits now. When their employers are required to pay something for their insurance coverage, the employers will not be able to shift the cost back onto the work force in terms of lower wages, and they will decide they need fewer workers.

But if you look at the people who are earning the minimum wage, many of them are students and young people. The important thing to remember about that particular group is that, under the administration's proposal, an employer does not have to pay for insurance for an employee under 18 years of age if that employee is a dependent child; in addition, employers do not have to cover employees who are full-time students under the age of 24. So the employment of those people would probably be unaffected.

Senator DASCHLE. Thank you, Dr. Reischauer.

Dr. REISCHAUER. In addition, there will be some job creation, probably because of the expansion of home- and community-based health care for the disabled.

The CHAIRMAN. Thank you, Senator Daschle.

Senator Durenberger?

Senator DURENBERGER. Dr. Reischauer, like you I am deeply grateful to the President of the United States for taking on the health care reform issue, and the First Lady likewise.

In the last year I have watched you for a day in Minnesota and then at various times deal with the situation in which you have been placed. I watched you all day yesterday or a good part of the afternoon. And I watched you react here this morning.

I have the impression that one of the most important things you have said is your comment about health care policy ought to make sense not just be written to some budgetary guideline. I could hear some laughter here when you mentioned 1965 and so forth. That is a reality that if we had had the 1980's, 1990's budgetary sense in 1965 would we have done that.

I must also say that the problem that we all face here is the adequacy of our knowledge base at any given point in time. If people in 1965 had known the nature of medical markets and what they

were doing to them in the period 1954 to 1965, how they would just inflame this fee-for-service system into doing great things for us as a country but without any consideration for cost, would they have done it.

Today the easiest thing to get budget estimates on is a single payer system—real simple. All you have to do is say, we are only going to spend so much money or allow so much of an increase and so forth and you can get savings. That is budgetary treatment.

But because our knowledge base today will not permit us to judge quality, it cannot tell us what rationing is or adequate access is or any of that sort of thing, that does not become an issue because the approach is budgetary. it is just savings. It is not quality or access or innovation or any of those things that Americans really care about.

So I want to underline what you said about the fact—and this is my words. What your report says to me more than anything else is the limitations imposed on health policy reform by the current budgeting process.

I am an author of a plan called Breaux-Breaux-Breaux and Durenberger. [Laughter.]

And as compared to the Clinton plan which gets us to 19 percent of the GNP in health care 10 years from now, I believe from my knowledge base that Breaux-Breaux-Breaux-Durenberger and some House Members will get you to 10 percent of the GNP in 10 years. You and I have had conversations on this subject. Ten percent of the GNP in 10 years. The difference is about $900 billion, which will buy you an awful lot of universal coverage.

You can do that without sacrificing innovation or quality or rationing or any of the rest of that sort of thing. The problem is, it cannot be estimated. It cannot be estimated. Because today's estimates are premised on basically a dysfunctional medical marketplace and for our premise is that you can price medical goods and services and you can create a market.

Professor Alain Enthoven, Dr. Reischauer, wrote you on January 18, 1994 a letter which suggests several things. One of which is that your behavioral assumptions for estimating the affects of health care proposals in November of 1993 may have an error in the estimating of the elasticity of demand. You may understand that. I am not sure that I do. As large as a factor of 10.

The CHAIRMAN. A factor of 10?

Senator DURENBERGER. Yes. Or it may be as high as 16. I am not sure. I just hope that maybe in writing we can get a reply to this.

He also suggests that using studies based on 1982 and 1984 data will give you a downward bias in estimating the elasticity of demand. And then suggesting that perhaps the better way for us in trying to decide how to get to markets and how to begin the process of estimating them would be if you were able to give us some range of estimates which would flow from some range of assumptions, because I will argue with the Clintons that the problem is not in their estimates. I do not think we should get into this $74 billion versus. The problem is in their assumptions.

So that if we could commit ourselves in some way to a process by which you would help us do estimates against assumptions and

give us a range like actuaries do when they are trying to estimate the cost of coverage, might not that be more helpful to us?

Dr. REISCHAUER. Certainly, it would. We have tried to do that in one aspect of our report on the administration's health proposal. We have estimated costs using premiums that are the same as those the administration used, premiums at the level we think they would be, and premiums 10 percent higher. So we have provided you with a range on that issue.

We certainly can do the same with respect to demand elasticities. Let me say that, just before I walked over here to testify, I finished editing my response to Professor Enthoven and will send it back to him today. I will be glad to send you a copy.

The CHAIRMAN. I wonder if we could put both that exchange in the record.

Dr. REISCHAUER. Yes, I will. I will be glad to do that, especially because I think he is wrong. [Laughter.]

[The information appears in the appendix.]

Dr. REISCHAUER. But on top of that, there is something of a fundamental misunderstanding here, and that is that the elasticity estimates that you and he are referring to, in fact, are not used in our estimate of the Breaux-Breaux-Breaux-Durenberger-Cooper proposal.

In fact, we agree with the major point, which is that these elasticity estimates are derived from marginal changes in a very mixed system and probably not applicable to large-scale reform efforts such as that one. As a result, for our estimate of that proposal, we have taken behavioral assumptions from the experience of large health maintenance organizations—HMOs—and managed care programs in the California State employee system and the Wisconsin system. So we have used very different numbers.

The CHAIRMAN. Well, we look forward to having your response and his letter.

Dr. REISCHAUER. Yes.

The CHAIRMAN. Senator Grassley?

Senator GRASSLEY. Thank you, Mr. Chairman.

Before I ask my first question, I want to call my colleagues' attention to chapter 3 of your report and also compliment you for that discussion. It seems to me to be particularly enlightening about the specific kind of program we are talking about here with the Clinton proposal.

I do not want to belabor the point here. But I just want to observe that if anybody was under the illusion that this is not a completely public and completely Federal takeover of the health care system they could not be under that illusion after reading your chapter 3, at least as I read your chapter 3. I have some things underlined here that I will highlight for anybody that is interested.

Now in regard to your ability to estimate. I think you have been very candid in the limitations in the kind of analysis that is represented in your report. The limitations are such that the estimates could be wrong by large magnitudes in either direction. I think you would agree with that.

For instance, we know that the estimates of the 1990 Budget Act have already been technically corrected by $190 billion and that has been upwards, and just by way of example the CBO report

notes a difference of some $36 billion between its estimates of what all businesses would spend on health care in the year 2000 and those made by the Lewin analysis.

In effect, is not the implementation of a plan as comprehensive as the President's kind of a great leap in the dark as far as knowing with any confidence what the many economic effects of the plan are going to be? And before you answer that: Is it not naturally the case that we tend to underestimate what various programs that we enact are going to cost anyway?

The CHAIRMAN. Surely not. [Laughter.]

Senator GRASSLEY. Surely yes. Please answer.

The CHAIRMAN. Yes and no.

Dr. REISCHAUER. Have I stopped beating my wife?

Senator GRASSLEY. Well, no. If that sounded like I was blaming you, I think I have complimented you on being better than some other government agencies and improving over the years.

Dr. REISCHAUER. Yes.

Senator GRASSLEY. I have been talking about too rosy of scenarios for 10 years as a member of the Budget Committee.

Dr. REISCHAUER. Right. Certainly the uncertainties that you highlight are there. The more fundamental the change the more uncertain the outcome becomes as you note. Often, we have not been very good at predicting even incremental changes in major benefit programs. That is a tremendous caution to bear in mind in any debate of health reform proposals.

As I pointed out in discussing our report, however, you have to weigh that uncertainty against the knowledge that staying the course with the existing system is going to create an increasingly serious set of health care problems in this country, with more and more people being uninsured. Then, maybe, the decision is between incremental approaches, for which we have some ability to estimate consequences but not perfect ability, and more major kinds of transformation, about which there is greater uncertainty but also greater prospects of achieving objectives that many people find desirable.

Senator GRASSLEY. I would like to ask you about premium caps. I think the administration has pretty consistently argued that premium caps are only a backup. How critical to your analysis are premium caps? Does your analysis assume that premium caps will be involved? And if so, when do you assume the premium caps would start to be used?

Dr. REISCHAUER. The administration's proposal has caps on the premiums for each regional alliance which will grow at a particular rate. Those rates are based on average growth limits for the Nation, but each regional alliance will get a different rate of growth depending on a complex set of factors.

That is one set of restraints. There is also another overall cap on Federal liability, which involves——

Senator GRASSLEY. I am talking about the premium caps.

Dr. REISCHAUER. The premium caps.

Senator GRASSLEY. The former.

Dr. REISCHAUER. All right. We have assumed that those caps will be effective or that we will be hitting them right from the beginning.

Now, Mr. Durenberger might argue that competition within this new environment will be such that, in fact, the premium caps are not needed because the price at which competing health care plans offer their benefits will be below the average level that is required in each regional alliance area. But we do not think that that will be the case.

Senator DURENBERGER. I think, if I may interrupt my colleague.

Senator GRASSLEY. All right.

Senator DURENBERGER. What Mr. Durenberger would argue is that is you put on premium caps as you point out every insurer will have the incentive to go right to the cap automatically and you will exaggerate the disparities that exist in the current system.

Senator GRASSLEY. Since he took 30 seconds, in regard to the Lewin analysis, they figure that premium caps would reduce the overall costs by 47 percent, or, in other words, that costs would be $47 billion lower than they would have been without caps. How much lower would health care spending be according to your analysis because of premium caps?

Dr. REISCHAUER. We did not do an estimate of that sort. What the Lewin analysts were saying is that we have a new environment. We provide everybody with basic insurance. That increases the demand and the costs for health care.

We change the environment in certain kinds of ways that generate the competition in the insurance industry that Mr. Durenberger is talking about. That will lead to a lowering of these costs. But the costs of the plans will still be well above the premium levels set by the administration. Then you would have to come down to those levels.

We did not try to differentiate those two aspects of the downward movement. It is a complex and controversial kind of estimate.

Senator GRASSLEY. Thank you.

The CHAIRMAN. Thank you, Senator Grassley.

And now, let us hear from Durenberger-Durenberger-Durenberger-Breaux. They are the ones who are in the know. [Laughter.]

Senator BREAUX. That is the way to go. [Laughter.]

The CHAIRMAN. Senator Breaux?

Senator BREAUX. Thank you very much, Mr. Chairman.

Thank you, Dr. Reischauer. I think that the work you have done is really an incredible undertaking. It is a massive program to look at and analyze. Can you tell me in layman's language what contributed to the major difference in the estimate of the Clinton administration which estimated a decrease in the deficit by $58 billion in a 5-year time frame and your estimate that it would increase the deficit by $74 billion in the same time frame? What are the differences that led to that major, what is it, $133 billion difference in the estimates?

Dr. REISCHAUER. Well, as is so often the case in my business, it is lots of little things plus a few big things. The biggest thing is that we think that the cost of employer subsidies will be much greater than the administration has estimated.

We have used a different estimating methodology for this analysis, one based on data from County Business Patterns, which we think is a better approach. But different analysts could argue that

point. This is certainly an issue about which reasonable people, reasonable professionals, will disagree.

In addition, we believe that the premiums for the standard benefit package will be 15 percent higher than the administration has estimated. Our estimate of premiums is very close to that of Lewin-VHI. It is very close to the Wyatt Corporation's assumptions, and it is well below the Hewitt assumptions. So I think we are in the ball park here on premiums.

Then there are lots of little things. The Joint Committee on Taxation felt that the revenue from constricting cafeteria plans would be less than the administration had calculated. And we included the impact on the Social Security trust fund in our estimate. When you have more early retirees, it means more people retiring at age 62 and receiving some benefits through Social Security. The administration did not include an estimate of those costs.

I might add—I hope you will not take this out of Senator Breaux's time—that we were very fortunate, because we went third in providing cost estimates. The administration went first, and it had the toughest time. Lewin went second, and we went third. We had a lot of help from people in the administration. Numerous individuals at the Office of Management and Budget, the Health Care Financing Administration, and the Department of Health and Human Services were there to help us understand the intricacies of this bill and to tell us how they did their estimating, which as far as I can tell was done without any bias at all. It was a first rate professional effort to get at these costs.

But, you know, as you gain experience, you have the opportunity to learn from it. I would like to thank them for that now.

Senator BREAUX. You had discussions in the report about both the National Health Board and the regional alliances which I found to be very interesting. Our regional alliances or health alliances in the Cooper-Breaux bill are really purchasing cooperatives which are not regulatory.

In the administration's alliance you point out that they would have an even broader and possibly more demanding set of responsibilities and then you list them. You say that they would combine the functions of purchasing agents, contract negotiators, welfare agencies, financial intermediaries, collectors of premiums, developers and managers of information systems, coordinators of the flow of information and money between themselves and other alliances; they would also have to implement the controls on the premiums under the direction of the National Health Board.

Then you point out that any one of these functions could be a major undertaking for an existing agency with some experience, let alone for a new agency that would have to perform them all.

That sounds like at the very least a real word of caution as to whether these new entities can do all of these things. Can you elaborate on that?

Dr. REISCHAUER. The administration's proposal contains a very ambitious schedule for phasing in the system it describes. We have accepted that schedule in our cost estimate. We thought that would be most useful to you and most valuable for comparative reasons, both for the administration's proposal and the proposals of others.

What we were trying to point out is that this proposal is going to be tough to implement in a lot of ways. Is it impossible? Probably not. This Nation can do almost anything if it really puts its mind to it.

Senator BREAUX. Is there a note of caution to go slowly in that statement?

Dr. REISCHAUER. There is, yes.

Senator BREAUX. Let me ask another question on the premium caps. I take it your assumption is that under the administration plan premium caps, cost controls, price controls will kick in.

Dr. REISCHAUER. Yes. The premium caps will effectively set limits on the costs of the standard package of benefits.

Senator BREAUX. In your discussion on premium caps you raised some cautionary notes as I read your report. In talking about how the premium caps will affect the health system, those of us who have argued against premium caps say that you could ultimately end up rationing health care in order to meet the caps.

And you talk about that. You assume that the limits on the rate of growth of premiums would be sustained even though they are likely to create "immense pressure and considerable tension." I do not know if those are words of art. But what do you mean by that? What are your concerns?

Dr. REISCHAUER. Those are terms of art.

Senator BREAUX. What do you mean?

Dr. REISCHAUER. As you know, art is——

Senator BREAUX. In the eyes of the beholder.

Dr. REISCHAUER [continuing]. Something you cannot describe in technical terms.

Senator BREAUX. But when you are talking about considerable tensions, pressures because of the premiums caps, really what are you concerned about?

Dr. REISCHAUER. Well, we have a system right now that is chugging along with increases of 10 percent a year in spending for health care. We are talking about slowing down the rate of growth of that spending rather substantially. Under the administration's proposal, it is going to be slowed down largely by the caps on premiums, which will then create many tensions and pressures within the health alliance areas, within the health plans, and across regions.

Our competitive system works that way, too, but there, markets determine what happens. There are pressures that occur, firms go out of business, and people cannot always afford products they would like to have. So that kind of pressure is not unusual.

It is also important to keep in mind, I think, that any effective method of bringing down the rate of growth of health care spending is going to create tensions and pressures of this sort.

I do not know what to call it—the Breaux-Breaux-Durenberger-Cooper-Cooper plan——

Senator BREAUX. Whatever. The other plan.

Dr. REISCHAUER [continuing]. Does this by imposing a pretty hefty tax on employer-paid premiums above a certain level. That is going to create tension, too.

The CHAIRMAN. Right.

Senator BREAUX. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much.

Senator Dole, you have been very thoughtfully listening to these questions for the last hour.

Senator DOLE. There was a good piece in The Wall Street Journal a couple of days ago about the science of predicting costs of health care.

I quote Mr. Meyer of the Economic and Social Research Institute. He says: "What is more, the sheer volume of data and the complexity of calculations involved often results in flaws creeping into big models. We have errors in the original data sets, forecasting errors, judgments that have to be made about important parameters, estimates that economists pull out of their heads, says Jack Rogers," director of Price Waterhouse and so forth.

Mr. Reischauer in an interview with Mr. Goslin of The Boston Globe, you say that financial figures in the massive pools are largely irrelevant. And I quote: "At some point the American people are going to have to edge up to the precipes, close their eyes, cross their fingers and jump." And I think there——

Dr. REISCHAUER. There was another phrase that he left out: "and hope they land in a soft place."

Senator DOLE. Well, that would be helpful. [Laughter.]

But we do not know where we are going. I think the point I would make, and underscore with Senator Grassley, I think these are predictions. Obviously, you do the best you can. I know the CBO was not responsible, but somebody estimated the costs of Medicare back in 1965 at $9.1 billion by 1990 and it was $67 billion. So there is a 644 percent difference.

Somebody probably told Congress at that time, and some of us were there, that this is what it is going to cost. I assume that you are telling us—yours might vary I assume a dollar or two over the 5-year period or 10-year period, whatever.

But I think you have to consider utilization and new technology which you cannot always do. If we do not tie up the drug companies totally, they may have a lot of breakthroughs and save a lot of lives in the future.

So I guess the point I would make is, these are predictions. We have to rely on these. Which leads me to the second point, I mean in fairness to the Clinton plan, will the CBO look at other plans? We have the Breaux—I do not know who takes credit for it.

Senator BREAUX. It depends on where you are.

Senator DOLE. Then you have the Chafee, et al., plan and the Nickles plan, the Gramm plan, the Michel plan, and the Wellstone plan, that I can think of now. You do not do this just by yourself, do you? [Laughter.]

Dr. REISCHAUER. If I told you the truth—that I really do—my staff would kill me. [Laughter.]

Senator DOLE. But I know it is a lot of work.

Dr. REISCHAUER. No—of course. We have prepared an estimate of the Cooper bill that was introduced in the 102d Congress; we have done an estimate of the McDermott-Wellstone bill already; and we have done an estimate of the earlier version of the Michel plan.

We have just now—as of 2:00 a.m. yesterday morning—come out from underneath the analysis of the administration's proposals.

There are a number of other proposals on our desks waiting to be analysed. Those include the new version of Breaux-Durenberger-Cooper, Nickles, Chafee, and several others.

It is beyond the capability of the Congressional Budget Office to do all of those in a timely fashion. These are brutal exercises. I have a staff that has not taken a day off for over a month, and they are going to need a few days off. Then we will get back to work.

What I need from the bipartisan leadership of the Congress—both sides—and the chairmen and ranking members of the committees that have primary responsibility for health care reform is some kind of list of priorities.

Senator DOLE. I think that would be helpful. I know you have addressed the President's plan and the others. But I would guess the President would say, well, what about the other plans. And maybe we can——

Dr. REISCHAUER. I think that is a fair statement, too. We have analyzed the administration's plan in tremendous detail, and we have looked at dimensions of it that we did not look at with respect to the other plans.

We did not look at the economic ramifications of the Wellstone-McDermott plan, for example. The administration would be justified, I think, in saying: "Let us level the playing field, let us look at each of these plans in all of their dimensions."

But I have a very limited staff. That staff is trying to provide you with estimates of other bills that are coming through, with estimates of the supplemental appropriation, with analyses of the President's budget submission, and on and on. We have a situation in which the resources for the Congressional Budget Office are lower in nominal terms than they were 2 years ago. Our staff is smaller, and yet more and more is being asked of us. We cannot do it all.

Senator DOLE. I think you make the point there. So I would be happy to help Senator Mitchell and the ranking member, Senator Packwood, and the Chairman to see if we could not give you some priorities because I know you cannot do it all.

I want to go back and try a similar question to one Senator Packwood asked and how the employer mandate in the Clinton plan differs from the individual mandate say in the Chafee plan. In the individual mandate, the money does not go to the government. It does not go to some alliance. There would be a difference. You say that in the Clinton plan these are Federal receipts. They would not be considered Federal receipts unless somebody bought through the alliance. Is that correct?

Senator PACKWOOD. Bob, let me give a partial answer that I discovered since I asked you. It is the Federal Harbor and Long-Term Workers Compensation Act. Because you are on navigatable waters, it is allegedly Federal and, therefore, there is Federal worker's compensation for these people.

And you can either self-insure or you can buy private insurance. Here is the way it is budgeted. The administrative costs of the program are on budget. There is a requirement to index the benefits by 50 percent. The cost of managing the indexing is on budget, not the benefits, but the costs of managing the indexing.

Then there is a Federal fund to pay employers if you have a second injury and it is a second employer, and it is a very small amount.

But those three added together in 1992 are $9.2 million on budget. They are $600 million of benefits that are off budget, because they are bought privately and they do not run through the government. So you have a very small amount on the budget and the rest of it off.

The CHAIRMAN. Well, you have cleared that up. [Laughter.]

Senator DOLE. Do you adopt that statement as a fact?

Dr. REISCHAUER. For that fund, I adopt it as a fact. But whether that is a precedent for an individual mandate is something that my staff will be looking into. Right now we are, in fact, examining this issue with respect to the Chafee proposal. These are very complicated issues and there are different dimensions that have to be examined.

I am not going to stand here and say: "Oh, it is an individual mandate and it does not go through the Federal Government, so it necessarily is nongovernmental activity." It may be; it may not be. We will certainly work with the sponsors of these pieces of legislation and with the committees responsible as we develop positions on this.

Senator DOLE. Could I just ask one other question?

The CHAIRMAN. Please do, Senator Dole.

Senator DOLE. If you eliminated the alliances, then that would change rather dramatically the impact of the Clinton plan, would it not, from your standpoint?

Dr. REISCHAUER. The alliances serve a set of functions, and one would have to ask who or what would replace the alliances in carrying out all of those functions. Only by answering that question would you be able to say whether eliminating the alliances affects the budgetary treatment of the administration's proposal.

Senator DOLE. The question you get at town meetings is that if 85 percent of the system is okay, why are we going to change all of that to take care of 15 percent of the system. Maybe it is 18 percent. It is a pretty good question that people asked as recently as this morning at a breakfast meeting I attended. I know this is not your responsibility, but I'd appreciate your views.

Dr. REISCHAUER. That is not my responsibility, but let me tiptoe up to the edge of it. On the one hand, the system is okay in the sense that people have coverage and the health care that they receive from, really, the finest medical establishment anywhere in the world is good.

But on the other hand, this system is creating incentives for basically uncontrolled growth in spending. And while people may be happy with their situations with respect to health care, they are not happy with the lack of growth in wages that they have experienced over the past decade and a half.

One reason people are not happy is that their employers have put more of their workers' total compensation into the fringe benefit of health insurance. Cash wages have suffered as a result. I think that 70 percent of the American people who are happy with their situation now would not be as happy if they really understood the consequences of the existing financing system for health care.

The CHAIRMAN. Fine. Thank you, Senator Dole.

Senator Packwood and I were going to do this, and the moment seems appropriate. I wonder if you would introduce your staff. They have been sitting behind, with a lot of body English going on there.

Dr. REISCHAUER. This is Paul Van de Water. Paul Van de Water was——

The CHAIRMAN. Yes, very prominently mentioned as author of chapters 2 and 3. Yes, Mr. Van de Water. Good morning.

Dr. REISCHAUER. I put him in charge of coordinating the entire activity. He is the Deputy Assistant Director of our Budget Analysis Division. Next is Rosemary Marcuss, who is the Director of our Tax Division.

The CHAIRMAN. Ms. Marcuss, good morning.

Dr. REISCHAUER. Gail DelBalzo is our General Counsel.

The CHAIRMAN. Good morning to you, counselor.

Dr. REISCHAUER. Doug Elmendorf is an Analyst in the Macroeconomic Analysis Division.

The CHAIRMAN. Mr. Elmendorf.

Dr. REISCHAUER. He contributed to and wrote much of the chapter on the economic effects of the proposal. Mark Desautels deals with the outside world, and the media, for the Congressional Budget Office.

The CHAIRMAN. Mr. Desautels, good morning.

Dr. REISCHAUER. Who has been saying "no comment" for the past 3 weeks. [Laughter.]

I wondered whether I should pay him for that. I mean, I could have gotten a recording machine. [Laughter.]

The CHAIRMAN. We welcome you and we thank you for your great work.

Dr. REISCHAUER. I might add that in the row behind I see Bob Dennis, who is the Director of the Macroeconomic Analysis Division, and Doug Hamilton, a Unit Chief in that Division. They, together with Doug Elmendorf, wrote the chapter on economic effects.

The CHAIRMAN. There is some finger pointing going on over there.

Dr. REISCHAUER. Excuse me.

Senator DOLE. It is a big office.

Dr. REISCHAUER. I make them come so that the hearing room is full. You know, I get embarrassed testifying.

Nancy Gordon is the Director of the Human Resources Division, which has a big group of health analysts—big, that is, for CBO—half a dozen people. And Linda Bilheimer is the reigning expert on the details of the administration's health care proposal. She wrote the first and last chapters of the volume.

The CHAIRMAN. We welcome you both and thank you again.

Dr. REISCHAUER. Thank you for bringing my staff to the attention of the committee.

The CHAIRMAN. Now our distinguished majority leader, Senator Mitchell.

Senator MITCHELL. Thank you, Mr. Chairman.

Good morning, Mr. Reischauer. Mr. Reischauer, the President has stated as his principal objectives of health care reform achiev-

ing universal health insurance coverage—that is every American having health insurance—reducing health care spending as a percentage of the gross domestic product, and achieving long-term deficit reduction.

While your estimates differ from those of the administration, and you describe those differences as modest, am I correct in my understanding that your report supports the President's conclusions as to those principal objectives? That is to say that the President's plan will achieve universal health insurance coverage, will reduce health care spending as a percentage of the gross domestic product, and will achieve long-term deficit reduction.

Dr. REISCHAUER. If it is implemented according to the legislative language in the proposal, it would achieve all three of those objectives.

Senator MITCHELL. Now I would like to ask you about costs and savings. Your report estimates that the cost of the assistance to families to help them buy health insurance will be $95 billion in the year 2004. Your report also estimates that the savings in Medicaid under the President's plan will be $93 billion in that year.

Am I correct in my understanding that under the President's plan the assistance to help families buy health insurance will be roughly offset by the savings in Medicaid?

Dr. REISCHAUER. That is correct, I believe.

Senator MITCHELL. That is correct. Right.

A third question deals with the effect on wages. Between pages 53 and 56 of your report you describe the effect of the President's plan on business and what may flow from that. I will read selected sentences from those pages and ask a question on that.

You state that: "The total costs that all businesses together would pay for health insurance for active workers would be about $20 billion less in the year 2000 if the proposal were implemented, rather than if the current system were to continue unchanged. The estimated reduction in the cost for active workers from the proposal would be even larger in subsequent years, reaching slightly above $90 billion in the year 2004." That is to say, you estimate that businesses would save $90 billion in the year 2004.

You then go on at pages 55 and 56 to say that: "For the most part the nation's workers shoulder the cost of employer's premiums for health insurance; and thus the significant savings that the administration's proposal would produce, compared with current policy, would be largely passed onto workers in the form of higher wages."

So am I correct in my understanding that you have concluded that if the President's plan were adopted the cost to American businesses would decline by an estimated $90 billion a year by the year 2004 or in the year 2004 and that those savings would logically be passed on to workers so workers' wages would rise up to $90 billion?

First I ask you two questions. Am I correct in that understanding? And second, can you be more precise in your estimate of the proportion of the $90 billion a year in savings that would be passed on to workers in the form of higher wages?

Dr. REISCHAUER. You have reached the appropriate conclusion. We think that the employers' contributions to employees' health in-

surance premiums are largely shifted back onto workers in the form of lower wages. To the extent that business costs were reduced, those reductions would lead to higher wages.

The vast preponderance of that $90 billion in savings would be passed on to workers in the form of higher wages. From the standpoint of business, firms are relatively indifferent about whether they are paying a health care premium or a wage. But from the standpoint of the satisfaction of workers, they will be happier if they are receiving what they believe is adequate or comparable health care and receiving higher wages. There will be a positive benefit from this.

Senator MITCHELL. So that if I may summarize your responses to these three questions, if the President's plan were adopted and implemented, all Americans would be insured against the costs of health care.

Dr. REISCHAUER. Yes.

Senator MITCHELL. Health care spending as a percentage of the gross domestic product would decline.

Dr. REISCHAUER. Yes.

Senator MITCHELL. Long-term deficit reduction would be achieved.

Dr. REISCHAUER. Yes.

Senator MITCHELL. Costs to business would decline by $90 billion in the year 2004, estimated.

Dr. REISCHAUER. Estimated, yes.

Senator MITCHELL. And the wages of American workers would increase by an amount close to $90 billion a year.

Dr. REISCHAUER. Correct.

Senator MITCHELL. So that all Americans would be insured. The deficit would be going down. Health care spending as a percentage of the gross domestic product would be going down and the wages of American workers would be increased by up to or close to $90 billion a year. Is that correct?

Dr. REISCHAUER. That is the judgment that we reached.

Senator MITCHELL. Thank you, Dr. Reischauer.

Senator CHAFEE. Hallelujah.

The CHAIRMAN. Thank you, Senator Mitchell. And thank whomever it was who said Hallelujah. I think we needed that. That is always a positive response.

Senator Danforth, you are next.

Senator DANFORTH. That is a common response by me, Mr. Chairman, but not in this instance. [Laughter.]

Dr. Reischauer, let me apologize if this is going over ground that Senator Durenberger and maybe Senator Grassley covered. But one of the theories of holding down the cost of health care has been managed competition. That is, you set up market forces and they do the job.

Another way is price controls. In this case controlling premiums. It is my understanding that in your projections you really do not place any weight on managed competition, but instead you are relying on the premium caps to control the costs.

Dr. REISCHAUER. In doing a cost estimate, it is not necessary to make a judgment like that, unless it was thought that the forces of competition that would be unleashed by the administration's pro-

posal would produce average premium levels below the limits that the proposal sets up.

Those limits, as you know, are fairly low. They are quite constraining relative to the current state of health spending. Our feeling was that although the competition within the administration's proposal should improve consumer welfare, it could have a limited effect on overall prices, so one would expect the various plans to compete in a constrained environment—in order to get down to these caps—to be at these caps, in fact.

Senator DANFORTH. Well, let me ask you this. Let us suppose that we pass legislation without premium caps, would your——

Dr. REISCHAUER. I would give you a cost estimate that would be quite a bit higher than the one we have given you in this report.

Senator DANFORTH. Can you give us that estimate?

Dr. REISCHAUER. Yes, I believe we can.

The CHAIRMAN. Fine. I think we would appreciate that. Is somebody in the back saying——

Dr. REISCHAUER. This is not something we can pull out of our back pocket. This question takes us back to the use of resources at the Congressional Budget Office.

Senator DANFORTH. Right. From my standpoint I think that that would be interesting information to have.

The CHAIRMAN. If we can have that, Dr. Reischauer, I think we need it. Do you not? There goes the one weekend you were going to get. We will negotiate.

Dr. REISCHAUER. We will negotiate, because you might not like what I say you have to give up to get that estimate.

The CHAIRMAN. Yes. Because there is an opportunity cost, is that not what economists say?

Senator DANFORTH. Can I just ask you this? You have said that the cost would be substantially greater without the premium cap. And you have also said in your report that you assume that proposed methods for constraining the rate of growth of premiums for the standard benefit package would be completely effective. That is your term—completely effective?

Dr. REISCHAUER. That is correct. If you read through the legislative language and you assume that this proposal is going to be implemented as the legislative language requires, it would seem that these premium caps would be completely effective.

Senator DANFORTH. And you have also said in the report that you assume there is going to be tremendous pressure to abandon premium caps.

Dr. REISCHAUER. Well, if there is——

Senator DANFORTH. I mean, you do assume that?

Dr. REISCHAUER. We do not assume that. We say that that pressure is a likely outcome.

Senator DANFORTH. Right.

Dr. REISCHAUER. If you did pass the administration's proposal as it stands now and then several years later decided to relax the premium caps, the Congressional Budget Office would have to score that and give you a cost estimate.

Senator DANFORTH. Right. But I mean you do assume there will be a lot of heat. I mean, I think you say that on page 76—"immense pressure and considerable tension" are the words you used.

Has it been the experience of the Congressional Budget Office that we in Congress are particularly good in sticking by caps that we impose?

Dr. REISCHAUER. In this hallowed chamber, where I was battered about over the Medicare Catastrophic Coverage Act, I would have to say that it has been difficult sometimes for the Congress to stick to caps that it has imposed. But at the same time I would have to say that you have done an excellent job since 1990 with respect to the caps that have been placed on discretionary spending through the Budget Enforcement Act and on entitlement spending through the pay-as-you-go discipline. So there is a mixed record here.

Senator DANFORTH. All right. Thank you, Mr. Chairman.

The CHAIRMAN. I am not going to let this opportunity go by without invoking Senator Byrd's, our President pro temporary, use of that 18th Century phrase, "flosa nosa prosa nihil pilification[sic]." Now get that right. [Laughter.]

It is from the House of Commons and it denotes the futility of making estimates.

Let us also record in the interest of the CBO that the Central Intelligence Agency, with vastly larger resources, 2 years before the Berlin Wall came down, solemnly informed us that the per capita GDP in East Germany was higher than West Germany. They could have checked that out with any taxi driver in Berlin.

So I think we ought to concede the difficulties that you have and admire the performance.

Senator DANFORTH. Mr. Chairman, the point that I was making is that, and a lot of people have made the point, that making projections, in fact the report itself says making projections, is something that is not that—you cannot put that great of reliance on it.

The CHAIRMAN. Right.

Senator DANFORTH. But if the projections are based on premium caps, I am one of three Republican Senators who supported premium caps incidently. But if the reliance is placed on premium caps you have an additional problem, which is not just a projection, an economist's problem, but it is the political problem of having the will to stick with those caps over a period of time.

The CHAIRMAN. I think that is a fair statement.

Senator Roth?

Senator PACKWOOD. Could I make a correction while he is sitting down?

The CHAIRMAN. Yes.

Senator PACKWOOD. The figures that I gave you, Mr. Director, on the Long Shore Act were given to me by CRS. They called up and then when they heard them—they were watching us. When they heard them, they checked them again and found out their figures were wrong.

I have given a figure of $9.2 million on budget——

The CHAIRMAN. That is called the Heisenberg Uncertainty Principle. The fact of being observed changed what is observed. [Laughter.]

Senator PACKWOOD. They have given a figure of $9.2 million. It is a significant difference. $9.2 million on budget, $600 million off. It is actually $109.2 million—they were off a hundred million—on budget and $500 million off.

The CHAIRMAN. That guy Heisenberg really had it, did he not.
Senator PACKWOOD. Thank you, Mr. Chairman.
The CHAIRMAN. Thank you, sir.
Senator Roth?
Senator ROTH. Thank you, Mr. Chairman.

Senator Danforth has addressed the one principal question I wanted to raise. But I would like to underscore the importance that I attach to our having a baseline based on what this program would cost without the premium caps. I think that is critically important as a means of addressing what the President's proposal would cost.

One of the questions that I would like to raise is about the credibility of the estimated cost of the insurance premium proposed under the administration's plan.

Let me begin by reading the following statement from an article by Wilfred Trevot, the chief executive of the Chamber of Industry and Commerce in Hanover, Germany that appeared recently in The Wall Street Journal. I might say that the German health care system has been cited by this administration, as well as a number of others, as being an excellent system.

But I think what he has to say is interesting, and I quote him:

"Perhaps the most interesting revelation from the German health plan is that it shows how unrealistic the Clinton plan is. In the U.S. the maximum premium to a health alliance will be about 10 percent of payroll.

"This is supposed to pay for health costs that now amount to 14 percent of GDP, set to rise to 17.3 in the year 2000 under the Clinton plan's reform projection 18.9 percent otherwise."

"If a 13.4 percent payroll tax in Germany is needed to finance 10.6 percent of GDP, it is hard to conceive how in the U.S. a much small payroll tax of 10 percent can finance the U.S. health care costs at a much larger share of 14 to 17 percent of GDP. The missing gap is too large to be filled with the designated subsidies. If you want to copy papers out of the German Social Policy Book, have your checkbook handy."

Senator ROTH. I wonder if you would care to comment on this statement I just quoted.

Dr. REISCHAUER. I ripped that article out of The Wall Street Journal when it appeared and put it in the stack of things that I planned to read when our report was finished. I do not think it would be appropriate for me to comment on it without reading the article. But I will be glad to provide you with a response for the record.

The CHAIRMAN. Could we ask that perhaps you would give us a response in writing when you have a weekend?

Dr. REISCHAUER. I will; certainly.

Senator ROTH. Could we arrange, Mr. Chairman, a very critical——

The CHAIRMAN. I have read the article. It was a very thoughtful article by a responsible person.

Senator ROTH. And I think it does deserve an answer.

[The information requested follows:]

COLUMN BY WILFRIED PREWO

Mr. Prewo's op-ed article in the *Wall Street Journal* compares the German payroll tax on employers and employees, which finances the bulk of German health care costs for private-sector workers, with employer and employee premium payments to health alliances under the administration's proposal, which would amount to only

about 20 percent of total costs. As a result, the premiums in the administration's proposal would be lower than the German taxes, as percent of payroll, even while the aggregate spending on health care in the United States would substantially exceed that in Germany, as a percent of GDP.

According to CBO's estimates, under the administration's proposal only about one-third of health care spending flows through the alliances (see Table 1). The proportion directly paid for by employers and employees is even smaller, because of subsidies to employers and individuals. Taking these into account, direct premium payments by employers and employees to alliances would amount to only about 20 percent of the total funding of the health care system in 2004.

TABLE 1.—PROJECTIONS OF NATIONAL HEALTH EXPENDITURES UNDER THE ADMINISTRATION'S HEALTH PROPOSAL, BY SOURCE OF FUNDS

[By calendar year, in billions of dollars]

	1996	1997	1998	1999	2000	2001	2002	2003	2004
Baseline									
Private:									
Out-of-pocket	194	206	219	233	246	260	275	291	307
Private health insurance	374	407	441	478	519	562	608	658	710
Other	45	48	52	56	59	64	68	73	78
Subtotal	614	661	712	766	824	886	952	1,022	1,095
Public:									
Federal	379	418	460	505	555	610	670	735	807
Health alliances	0	0	0	0	0	0	0	0	0
State and local	169	184	200	216	234	253	273	295	318
Total	1,163	1,263	1,372	1,488	1,613	1,748	1,894	2,052	2,220
Changes from Baseline									
Private:									
Out-of-pocket	−9	−19	−33	−36	−39	−43	−46	−50	−53
Private health insurance	−50	−138	−354	−387	−422	−467	−508	−551	−597
Other	0	0	0	0	0	0	0	0	0
Subtotal	−59	−157	−387	−422	−460	−510	−554	−601	−650
Public:									
Federal	5	−6	−49	−68	−78	−84	−93	−108	−127
Health alliances	74	208	542	563	585	635	668	703	740
State and local	−7	−23	−66	−72	−78	−90	−97	−105	−114
Total	13	22	40	1	−30	−46	−75	−110	−150
Administration's Proposal									
Private:									
Out-of-pocket	186	187	187	197	207	217	229	242	254
Private health insurance	324	269	87	92	97	95	101	107	114
Other	45	48	52	56	59	64	68	73	78
Subtotal	555	505	325	344	363	376	398	422	446
Public:									
Federal	384	412	411	437	478	526	577	627	681
Health allisnces	74	208	542	563	585	635	668	703	740
State and local	162	161	134	145	157	163	177	190	204
Total	1,176	1,285	1,411	1,489	1,583	1,700	1,820	1,942	2,070

Source: Congressional Budget Office.

Senator ROTH. Now, Dr. Reischauer, in the last chapter of your report entitled "Other Considerations" you raise serious questions about how all of the intricacies of the Clinton plan will work. And yet on pages 25 and 26 of your report you state the following: "The estimates in the CBO report assume that the proposed methods for

constraining the rate of growth of premiums for the standard benefit package would be completely effective."

So as I read this, your study assumes the expenditure caps, the price controls, other cost containment mechanisms in the President's plan work, and then you show that the President's plan will still be short some $166 billion, eating up all of the administration's claimed $59 billion of deficit reduction and adding an additional $177 billion.

Still you indicate you believe the President's plan will basically work; is that correct?

Dr. REISCHAUER. I do not think that that is exactly what the report says. First of all, I think that the net impact on the deficit over the 1995–2004 period is $126 billion, not the $160-odd billion that you referred to.

In estimating the cost of the proposal, we assumed that it would be implemented according to the time schedule that is laid out in the bill. We point out in the last chapter of the report that it will be very difficult to gather the data and go through the institutional changes that are required to meet that schedule.

We examined the premium limits that are in the proposal, and we judged them to be an effective mechanism for restraining the growth of premiums for the proposal's standard benefit package. We also point out, though, that that restraint will create social pressures in this country. And the real issue is whether the institutional and political structure of the Nation can withstand those pressures. We have no ability to judge that.

Senator ROTH. The point I am trying to stress here is that in your study you are assuming that the restraints do work. My concern is, if they do not work where do we go.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Roth. I think that was the purpose of that closing chapter.

Dr. REISCHAUER. It was, yes, sir.

The CHAIRMAN. Senator Baucus?

Senator BAUCUS. Thank you, Mr. Chairman.

I would like to just pursue a little bit a subject that has already been covered, that is managed competition. Why is it that you felt that virtually no savings is achieved with the managed competition?

Dr. REISCHAUER. Are we talking about managed competition with respect to this bill?

Senator BAUCUS. Yes, with respect to this bill—the plan.

Dr. REISCHAUER. I said that we did not make a judgment on that. We did not have to make such a judgment to do our cost estimate.

Senator BAUCUS. Now if you are——

Dr. REISCHAUER. The judgment that must be made is whether the managed competition, or the competition that will occur within the framework of the administration's proposal, would result in average premium levels in the various alliance areas that would be below the caps set by the National Health Board.

We thought that there was little likelihood of that being the case. Consequently, there was no need to estimate the effect of managed competition, because the effective constraint on the system would

be the limits imposed on average premiums by the National Health Board.

Senator BAUCUS. So you are saying that that cap, whether it is a tax cap or a premium cap or whatever, it forces the savings.

Dr. REISCHAUER. Yes.

Senator BAUCUS. Therefore you did not look for additional savings under managed competition; is that correct?

Dr. REISCHAUER. Yes. To the extent that managed competition brought you down close to those premium caps, then the amount of pressure that we were talking about before—that I was talking about with Senator Roth—would be less.

Senator BAUCUS. Now back to the savings achieved as a consequence of the cap and addressing to some degree Senator Danforth's question whether politically this institution can hold the line, that is hold those caps, those limits, and also adding in your repeated comment about the social tensions and the pressures that are caused as a consequence of the cap.

Could you delineate what you see as the most probable forces, upward forces, on the cap, that is the sources of the most probable upward pressures on the cap that this Congress would have to deal with, attempting to decide whether to raise the cap or not? Would it be reduced benefits or would it be some other pressure that you see? If you could just go through what you see some of those contentions in our social system to be.

Dr. REISCHAUER. Well, I am really not in a position to give you a thoughtful answer on that. But it is the hope of many that as premium levels are brought down, most of the savings will come from simplifying administration and from eliminating services that are ineffectual or unnecessary. And if that takes place, then there will be relatively few pressures.

But even in those cases, one has to remember that to an analyst or a health care expert, administrative costs might look like waste and inefficiency, but to you, they might look like the job of one of your constituents who works in the billing room of a hospital.

Some inefficiencies in our system result from the fact that we are willing to run our hospitals at roughly 65 percent of capacity and that we want to keep in existence many small hospitals that have occupancy rates below 50 percent. A rational person who was not subject to the human implications of the decision might say, "Let us run our hospitals at 90 percent of capacity. Let us close those small institutions that cannot keep their occupancy rate up above a certain level."

Decisions like those that might mean that some people would have to travel farther to receive care. They might mean that a large employer in a small town would disappear. And those are the kinds of pressures that you have been under in the past and that you would be subject to in an even greater degree, not only with regard to this plan but with any proposal that sought to lower the rate of growth of national health spending in this country.

Senator BAUCUS. Did you at all attempt to address the affect on quality of care, the affect caps would have on quality of care, even assuming the guaranteed benefits?

Dr. REISCHAUER. No. We say in the report that quality of care is something that should concern you. We do not know the extent

to which reduced spending would be reflected in lower-quality care rather than in less waste in the system.

It is impossible to know. Those questions will play themselves out differently in different market areas. What might be true in Minnesota might not be true at all in Georgia. There is really no way we can provide you with anything more than a list of the items that you should be concerned about.

Senator BAUCUS. Earlier in your statement you said that although there is no aggregate affect on employment, that is appreciably, there might be significant affect on certain firms. I guess particularly those firms that do not now provide health insurance or those firms who maybe have a very healthy work force.

Did you quantify those two categories at all? Did you attempt to deal with that in some basis so we can get a handle on how much of a shift that would be for those firms in those categories?

Dr. REISCHAUER. I do not think we did, no. Our analysis was conducted at a more aggregate level.

Senator BAUCUS. All right. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Baucus.

I wonder if I could just ask, the fact that our hospitals are running at 65 percent of capacity reflects advances in medicine to a large degree, does it not. And medical advances do not necessarily increase costs. They sometimes decrease them. But then you have this adjustment to make.

Dr. REISCHAUER. It is also worth noting that a lot of health spending in America is for amenities. There are aspects of the health care system that we like but that may not have a whole lot to do with health outcomes.

Whether I can schedule a routine office visit with my doctor 2 days from now or whether I have to wait 3 months will probably have no impact on health outcomes. Whether I share a room in a hospital with five other people or have a single room with a television set and other amenities that are unknown in many other industrial countries's hospitals does not affect health outcomes. So we can—if we decide we want to—squeeze our health care system and make it less consumer friendly without necessarily hurting our health outcomes.

The CHAIRMAN. Take out the television sets and drive the nurses crazy. Is that it? [Laughter.]

No, we are not going to do that.

Senator Rockefeller?

Senator ROCKEFELLER. Mr. Chairman, what you said is correct and also the fact that a lot of in-patient services have been moved to out-patient services in hospitals, which is also due to medical efficiencies.

Dr. Reischauer, the major difference as I see it between the Breaux-Durenberger managed competition bill and the President's managed competition frame work is the tax cap. So if we substituted the tax cap which is increasing taxes on middle income people's health benefits for the premium cap which is limiting insurance company's premium increases, would we get the same level of savings?

Dr. REISCHAUER. I think it would be highly unlikely. We have not done an estimate of that sort, but my gut feeling is that the tax cap that is in the Cooper-Breaux bill would not produce the same kind of savings that the premium caps in the administration's proposal would produce.

Provided that this committee and the bipartisan leadership want us to look at this issue, I think its analysis would certainly be a good use of resources.

The CHAIRMAN. I wish you would take that as something we would like you to do.

Senator ROCKEFELLER. One of the problems that we obviously all have had in trying to deal with and design bills that assure coverage, and at the same time guarantee affordability, is that we have to provide assistance to those who cannot afford health insurance and assuring affordability means that we somehow have to guarantee that costs will be reduced. We have to do that for them.

Anyone who has tried to draft a health care bill, we all know that we run up against CBO scoring rules on what will actually produce savings. Having said that, obviously I want to emphasize that I know that your scoring rules are not just dreamed up by your staff, but rather is based on the best and latest data on health care that is available.

Now that is a broad area statement. In the past, and I refer to Health America and some others bills, CBO has not attributed any significant savings in the way of cost savings to administrative simplification measures, single forms, et cetera. Am I correct?

Dr. REISCHAUER. No. We have estimated rather large administrative savings for single-payer plans, but they have been nowhere near as big as——

Senator ROCKEFELLER. The administrative simplification measures and single forms. I did not say single payer—single forms.

Dr. REISCHAUER. I did not understand whether you had asked me about savings with respect to a certain bill or in general. What I am saying——

Senator ROCKEFELLER. What I am trying to do is get within what I consider a legitimate level of cost savings, which I think CBO has consistently declined to score, and thus this tremendous difficulty of CBO scoring and the difficulty that it provides us as genuine policy makers in trying to produce something useful.

Let me just read them. Malpractice reform. You in the past have not done that. You did not on Health America. Insurance reform, elimination of medical underwriting. You did not attribute any savings in your CBO scoring. You did not give any significant savings to that already in work that you already have been responsible for yourself.

Fraud and abuse measures. Prevention, an enormous concept. Primary care taking place where it has never taken place before. CBO has declined to score savings on something called prevention, which is at the heart of the President's bill and outcomes research. Or, for example, practice guidelines. You, yourself, just used the word "health outcomes" and yet CBO has declined to score, hence the problem for the policy people—us.

You have declined to score outcome research. You have declined to score practice guidelines to any significant effect at all.

Dr. REISCHAUER. I think the important——

Senator ROCKEFELLER. I am curious why.

Dr. REISCHAUER [continuing]. Word that you used is "significant." We have examined the elements of the various health proposals and consider the savings that are likely to result from the legislative changes that you are suggesting as not being tremendously large.

Senator ROCKEFELLER. Yes, and that is something——

Dr. REISCHAUER. For some of those changes, their impact increases over a long, long period of time. Some of those effects are very uncertain.

For example, we hear talk about outcomes research and maybe practice guidelines, both of which I think would be excellent steps forward. We know what will happen in certain circumstances, which is that inappropriate treatments will be reduced. But practice guidelines and outcomes research could move us in the other direction as well, toward increased levels of care. For example, people who had not been receiving care would then be receiving appropriate services. It is a balance; these steps do not all reduce costs.

Prevention is another such area. On the one hand, health outcomes will be improved, and in some areas we will catch things using modest interventions early on that would be very expensive to treat if left until later. In that case, savings would result.

But on the other hand, you will be providing preventive services to many children or many individuals who for one reason or another may not be receiving periodic care the way they should but who are very healthy. So the consequences of not receiving periodic care are inconsequential because they were not going to have this disease or malady anyway. In that case, costs would be higher. So these investments work in both directions—sometimes the net effect is to lower costs, but sometimes it is to raise them.

Senator ROCKEFELLER. My time is out, Mr. Chairman, but I am baffled by this and it makes it very, very difficult because it causes one to have to do things for the purposes of avoiding CBO scoring which do not necessarily lead to better results.

The CHAIRMAN. Right. I wonder if we will not find this a useful area to discuss further by CBO. We have a number of things. If there are matters which you have found de minimis or perhaps unmeasurable, maybe you could tell us that.

Dr. REISCHAUER. Let me just add that it is useful to us if you bring to our attention academic studies or analyses that shed light on these issues. We have a staff that obviously is not filled with medical experts. We read the literature to the extent that we can and study these issues, but I am sure that there is evidence that come to your attention and not to ours. We are perfectly willing to change our estimates and our methodologies based on new information and new findings.

The CHAIRMAN. Can we just take that as a fair exchange and an undertaking. Work in progress.

Thank you, Senator Rockefeller.

Senator Conrad?

Senator CONRAD. Thank you, Mr. Chairman.

First of all I want to say I watched you yesterday in your testimony before the House Ways and Means Committee. I thought you

conducted yourself with great integrity and great professionalism and that all of us owe you a debt of gratitude, and whether we agree with every specific point that you have made is beside the point. I think you conducted yourself with real integrity. That is important to the system, and you ought to be commended for it.

There were a series of questions that Congressman Levin put to you yesterday that I thought were very useful and that I would like to just repeat, because I think they should be on the record here as well.

Congressman Levin referred to the questions that he gets when he goes home and they revolve around the question of cost. They revolve around the questions of coverage, choice and quality. He asked you in comparison to the current system does your study reveal that cost is less under the President's proposal than under the current system. Could you give your answer?

Dr. REISCHAUER. Yes.

Senator CONRAD. The President's proposal provides universal coverage and your study has concluded that that is the case?

Dr. REISCHAUER. Yes.

Senator CONRAD. You also said something that has not been an issue here today, but that I found interesting. In response to the question from Congressman Levin as to whether or not more choice is provided under the President's plan than under the current system your answer was?

Dr. REISCHAUER. My answer was that the vast majority of Americans would have more in the way of choice under the administration's proposal than they currently have. They would be choosing from a menu of insurance plans offered by their regional alliance. Most of us can only choose those plans that our employer puts in front of us. Often, our employer puts only one plan in front of us and says: "Either this or nothing."

In the health insurance environment that the administration's proposal would create, I would be able to choose a plan that no one else on the CBO staff had chosen. My choice would not be affected by where I worked. That, I think, is an incontrovertible fact.

Senator CONRAD. So just to sum up, on the question of quality you were silent in the study because that was not within the purview of the analysis done?

Dr. REISCHAUER. Yes, and in addition, we have no ability to answer that question.

Senator CONRAD. So in fairness, the conclusions that you came to is, the Clinton plan compared to the current system is lower cost, more coverage, more choice. Those are the conclusions of your study?

Dr. REISCHAUER. Yes.

Senator CONRAD. Now that is the good news.

Dr. REISCHAUER. I was going to say, those are some of the conclusions.

Senator CONRAD. Yes, some of the conclusions. Let me go to a question that disturbed me, because in your study you say that we in 1993 in this country were at 14 percent of our National income going to health care. The year 2004 with a failure to act will go to 20 percent of our National income going for health care; is that correct?

Dr. REISCHAUER. Yes. By 2004 and with the administration's proposal in place, we believe that national health expenditures, as a share of gross domestic product—GDP—would be a little more than 1 percentage point lower than they would be otherwise.

Senator CONRAD. So under the President's plan we would go to 19 percent of our National income going for health care from a current 14 percent?

Dr. REISCHAUER. Yes. I do not know for certain what the comparisons would really be because we do not know for sure how the world will look in the year 2004 if no reforms are adopted.

Senator CONRAD. Right. With no reform adopted, under your analysis we go to 20 percent of national income. With the President's plan we go to 19 percent. I mean just to say as one member of the committee, that bothers me. That worries me.

We are saying we are spending too much of our National income now on health care and under the President's plan it is less than under the current system, but it is still a substantial increase over what we are spending now for health care.

Dr. REISCHAUER. That is correct.

The CHAIRMAN. Senator Conrad, just for clarification, when you say national income, do you mean GDP?

Senator CONRAD. Yes. I am not sure GDP means anything to most people. I try to——

The CHAIRMAN. National income does.

Senator CONRAD. Sir, I try to translate it in a way that maybe people who are listening——

Dr. REISCHAUER. I do not want to get into a debate with you, but national income and GDP are two different things.

The CHAIRMAN. Do not say a word. [Laughter.]

Senator CONRAD. But it is a pretty good proxy. Let me just ask the next question, because the other concern I have is the alliances. You went through yesterday in your report some of the functions that the alliances will have to perform. It will combine the functions of purchasing agents, contract negotiators, welfare agencies, financial intermediaries, collectors of premiums, developers and managers of information systems, coordinators of the flow of information and money between themselves and other alliances.

And you say, and I quote, in the report: "Any one of these functions could be a major undertaking for an existing agency with some experience, let alone for a new agency that would have to perform them all." Is that correct?

Dr. REISCHAUER. That is correct.

Senator CONRAD. Let me just say, Mr. Chairman, I think this point deserves attention because we just went through a bitter experience I believe with the RTC where we set up a whole new financial structure. I am very concerned when you start talking about setting up whole new structures to deal with these complicated issues.

The CHAIRMAN. Well, thank you, Senator Conrad. And again, we take note that was from the chapter 5, Other Considerations, which we have all obviously found helpful indeed.

Senator Riegle?

Senator RIEGLE. Thank you very much, Mr. Chairman. Let me say at the outset that I share some of the concerns expressed by Senator Rockefeller and also Senator Conrad.

I want to talk about the time period over which you have looked at these cost effects that hit both the government and then society as a whole. I have been arguing for some time that if we just look at the financial impact over the traditional 5-year time period we really put ourselves in a straight jacket so that we cannot do a meaningful analysis.

To your credit you have stretched it out to 10 years. I think that is a very valuable approach that you have used. I want to suggest to you that I do not think 10 years really does this job either, although it is much more meaningful than 5.

Let me tell you why I say that.

Dr. REISCHAUER. I agree with you completely.

Senator RIEGLE. All right. This is important because I want to try to engage the Chairman on this point as well. That is, if you look at Hawaii, which is the one State that has had universal coverage now for about 20 years, it took about 10 years, the first 10 years, for the cost lines to break apart from what was actually happening in the rest of the country, in terms of health expenditures as a percentage of their economy.

So once they got everybody enrolled in a universal health care system, the cost relationships remained about the same for about 10 years, but then at about 10 years they began to break apart.

And over the second 10-year period of time, because Hawaii began to get certain efficiencies and economies and health outcome benefits by having people getting better preventive care and so forth, the cost line split apart. We now are told that Hawaii's health costs are running about 8 percent of their economy and the rest of the country is at about 14 percent.

But the breaking apart of those two cost lines happened between years 10 and 20, if you will, as the experience was mounting.

I have looked at that and the logic of it is quite strong, I think. It means that if we take an arbitrary cutoff date of the year 2004, which is 10 years out, we get one part of the picture. But we may be missing a very significant part of the picture. If we are going to have an exercise of what you call sovereign power, which indicates the majesty of the decision that we make here, we must really look at what the effects will be over time in terms of good health.

So when my friend Kent Conrad says that we are out at 19 percent of GDP in the year 2004 for health care, it may be a real bargain. Because, if we are not alive, our money is not worth much to us, is it? If our kids or our parents are sick and are not being treated, what good is our money?

So I do not mind spending what we need to spend on good health because we are all on a trip to the cemetery and if we are paying attention to that, other things we might want lose their relevance.

So I think we do have to keep health expenditures——

The CHAIRMAN. Senator Riegle, would you like to put that another way?

Senator RIEGLE. Is there another way we can say that?

The CHAIRMAN. We are all mortal. Would that be all right? [Laughter.]

Senator RIEGLE. Having said that, when I look at your numbers I think we need to try to size up what 2004 to 2014 might look like. Because the Hawaii experience tells us that you really need about a 20 year projection at how these numbers sort out.

Fortunately, our Chairman is a historian and pays attention to important details like that and will grasp the significance of that point. Taking your chart on page 26, I want to confirm two numbers. In the middle of that chart, are you saying that if we adopt President Clinton's plan and we add up all the costs and all the savings through the next 10 years, out to the year 2004, the Nation as a whole will save $337 billion in health expenditures? Am I reading that correct? That is the net saving over that 10 year time span.

Dr. REISCHAUER. I have not added up those numbers. But if you have added them up correctly——

Senator RIEGLE. Well, you can double check them. We have, and I think you will find those numbers add up to a net saving of $337 billion to the country.

Dr. REISCHAUER. Yes.

Senator RIEGLE. Now if you read then across the Federal spending line, which is the part that we have to be accountable for here, the table seems to indicate that over that 10-year period of time the Federal Government would spend $608 billion less than if we did not enact President Clinton's plan.

I would just like to have your own actuaries confirm those two numbers, because those are big savings. I think the public is finding it very hard to follow all of the details because this is so complex. I think they are interested in knowing whether we save money and whether we cover everybody.

The math, according to your chart, shows me that the country would save $337 billion over the next 10 years with the Clinton plan and the government alone would save $608 billion with the Clinton plan. Is that right?

Dr. REISCHAUER. This table is a confusing one.

Senator RIEGLE. I am trying to make it a little less confusing.

Dr. REISCHAUER. It has been confusing to people on my staff as we have tried to put this analysis together. This table with its breakdown by source of funds—private, public, and then within public Federal, Health Alliances, and State and local—is really a description of who is paying the health services.

So if health alliances receive money from the Federal Government in the form of subsidies to buy insurance for lower-income people, that money is recorded in the Health Alliances line, not in the Federal line. Consequently, it is incorrect to sum up the Federal line or the State and local line and assume that that total represent reduced burdens for the government sector.

Similarly, the private line in the top panel on that table, titled Baseline——

Senator RIEGLE. Right.

Dr. REISCHAUER [continuing]. Includes the current spending by employers and employees for employment-based private health insurance.

Senator RIEGLE. Right.

Dr. REISCHAUER. Under the administration's proposal, the payments that are made by employers and employees for their health insurance plans go into the Health Alliances line. But we have to remember that, ultimately, there is only one source of funds in the United States, and that is the people of the United States. Businesses are owned by people, and governments really run on the taxes that people pay to them.

Senator RIEGLE. But you are not disputing, I mean unless the chart is wrong——

Dr. REISCHAUER. I am not disputing your total on——

Senator RIEGLE. No, no, you are not disputing the fact that the national savings that you show here for the 10-year period of time is $337 billion; is it not?

Dr. REISCHAUER. That is correct.

Senator RIEGLE. I think that is the key, Mr. Chairman.

Dr. REISCHAUER. Yes, it is.

Senator RIEGLE. Because what the Clinton plan does, you boil it all down, it covers everybody over this time period and it saves at least that much money according to your analysis—$337 billion.

I think Senator Rockefeller is right. I do not think we have factored in all the savings because there are some things you do not feel comfortable hanging a dollar sign on that we know will save money. And I accept that point.

But what you do feel comfortable hanging a dollar sign on lets you sign your name to this estimate here today; you believe we can save $337 billion over the next 10 years and cover everybody if we go to the Clinton plan. I am talking about now Federal expenditures and national savings.

Dr. REISCHAUER. National health expenditures.

Senator RIEGLE. And national savings.

Dr. REISCHAUER. Correct.

Senator RIEGLE. That is not bad. I would say that is a big gain over where we are now.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Riegle.

Senator Chafee?

Senator CHAFEE. Thank you, Mr. Chairman.

First, I want to reinforce what Dr. Reischauer said about the President, but for the President's actions in pressing forward as vigorously with health care we would not be where we are in this debate. So the President and Mrs. Clinton deserve a lot of credit.

Second, could you help me out? I see a dichotomy here, Dr. Reischauer, in what you are saying and I might be mixed up. In response to Senator Mitchell's question it seems to me you predict the arrival of the millennia, it is paradise on earth.

What happens is, everyone gets health insurance, the workers receive a $90 billion pay raise, and you have just added to it with the government saving $337 billion as Senator Riegle says.

Dr. REISCHAUER. I did not add that to it.

Senator RIEGLE. He said the country saves $337 billion. That would be the national figure.

Dr. REISCHAUER. That was national health expenditures.

Senator CHAFEE. That is lovely, I must say.

The CHAIRMAN. Well, what did you expect.

Senator RIEGLE. Let us put you down as a co-sponsor then.

Senator CHAFEE. Now let me just move now in view of that, and here is what I see as a dichotomy that perhaps you can help me on, on page XII of your report it says as follows: "Estimates of the interactive affects of so many complex changes to an industry that encompasses one-seventh of the economy are highly uncertain." And the head of this paragraph is "Uncertainty of Estimates."

"Assumptions used by the CBO and other analysts about people's behavioral responses to new incentives are frequently based on research evidence from small changes in the existing market place," and on you go to say "there is no precedent for estimating the effects on health spending or the economy."

So here you write down what I sincerely believe, that this is totally unchartered waters. We are dealing with one-seventh of the economy and at the same time, with some carefulness, you predict that everything is going to be lovely. Am I missing something?

Dr. REISCHAUER. Well, I think that I have been fairly careful to say that our estimates depend on the administration's proposal being implemented as called for in the legislative language, number one. Number two, I began my remarks here this morning by stressing exactly the point that you have brought up, the uncertainty of these estimates.

Now, I could come here and say: "Here are some words, but I cannot give you any numbers because there is so much uncertainty." There are things over which the Congressional Budget Office does sometimes throw up its hands and say: "We just cannot do it." Or I could come and I could say: "We have no really scientific basis for estimating the range of uncertainty, but it could be anywhere. So in the year 2004, say, we could see anything from $2 billion increase in costs to $350 billion worth of savings."

Then what would happen is that those of you who oppose this plan would run out and say: "CBO said costs are going to increase by $2 billion," and those of you who were in favor of the plan would run out and say, "CBO says it is going to save $350 billion."

Senator CHAFEE. I get the point.

Dr. REISCHAUER. We think the most useful thing to do is to provide you with our best estimate but then qualify that estimate with a clear admission that there is a lot of uncertainty around those numbers. That is what we have done.

Senator CHAFEE. Well, I could not agree with you more. In our legislation, which I do hope you will be able to give us some estimates on, and we will try and follow the procedure you outlined with the Chairman and so forth here. But as you know, we adopt a so-called pay-as-you-go approach.

We do not give the broad new coverage immediately. We start at those at 90 percent of the poverty level or less and then we pause and take a check and see—first of all we implement all the reforms immediately. I regret that you were not able to break out some of the savings like malpractice reform, administrative reform and so forth.

But we believe there are substantial savings there. But we are not sure. So, therefore, we proceed to each year increase of coverage for those who are not covered, who cannot afford the coverage, up to 100 percent of poverty and so forth, eventually getting

on a sliding scale of Federal reimbursement Federal subsidies to those at 240 percent of the poverty. Could you comment on that so-called pay-as-you-go approach which we believe is wise?

Dr. REISCHAUER. Well, certainly, it reduces the risk that we might make a large mistake, because it is basically an incremental, one-step-at-a-time approach toward the same long-run objective as in other proposals, but an approach that allows for midcourse corrections of various kinds.

Senator CHAFEE. I have great trouble with the administration's proposal on leaping into the entitlements without this pause. For example, I find bizarre the proposal that the Federal taxpayers would pay for early retirees' medical health insurance, 80 percent of it.

Now it is true that there is a tax cap. Is the tax cap $120,000 income for a married couple?

Dr. REISCHAUER. Yes, there is a high-income limit to the subsidization of the employer share of early retirees' benefits. You are right.

Senator CHAFEE. I find that hardly much of a means test. In other words, if you——

Dr. REISCHAUER. Yes, you are not being mean to too many people, if that is what you mean. [Laughter.]

Senator CHAFEE. Thank you. My time is up, Mr. Chairman.

The CHAIRMAN. Well, now if you have another question, please.

Senator CHAFEE. All right. The other question I have is as follows. It seems to me that you dismiss the efficacy of the so-called tax cap. That is, where you arrive at—and how you arrive at it we can debate—but you arrive at what is a reasonable cost of a program.

Then anything that the employer provides above that in cost, the cost to the employer is nondeductible to the employer and taxable to the employee. It seems to me that that encourages everyone to go for the lower costing plan. Not lower costing quality because all of the plans involve a uniform benefit package. But you seem to dismiss that as being very inefficient or not having much of a downward thrust on cost.

Dr. REISCHAUER. Well, let us keep in mind that most American taxpayers face a marginal income tax rate of 15 percent. With that rate, it would hardly be a huge disincentive if employers' contributions to health insurance premiums were treated as taxable income to individuals.

Right now, the employee share of premiums, the part that you and I pay and that is taken out of our paychecks, is taxable income. Taxing that share has certainly not been an effective brake on the expenditures of our current system.

Senator CHAFEE. Thank you.

The CHAIRMAN. Thank you, Senator Chafee.

Senator Bradley?

Senator BRADLEY. Thank you very much, Mr. Chairman.

Dr. Reischauer, once again, thank you very much for your testimony and your analysis. I think it is very helpful to help us focus.

It seems to me that one of the new aspects in the President's program is the health alliance. There is money that comes into the health alliance from a variety of sources and the assumption is

that the amount of money that comes in is sufficient to pay the premiums for all the citizens of a particular jurisdiction—a State, a city or whatever.

I would like to ask you about two of the streams of the money into the health alliance. One is the money from the private sector. Large corporations pay up to, what, 7.9 percent of payroll and small——

Dr. REISCHAUER. They pay up to 7.9 percent. Many of them would be paying a flat premium amount.

Senator BRADLEY. Up to. Right.

And smaller ones are, if you have 75 or fewer employees you are capped at 3.5 percent?

Dr. REISCHAUER. No, it is a complex scale. For employers that pay average wages, I believe, of $12,000 or less and have fewer than 25 full-time-equivalent employees, the cap is 3.5 percent.

Senator BRADLEY. Right. So the lower your wages the lower you get close to 3.5 percent.

Dr. REISCHAUER. And then gradually the figure goes up to 7.9 percent of payroll.

Senator BRADLEY. My question to you is, if there is this difference between 7.9 and at the low end 3.5 and it is based primarily on size of firm, why would not a lot of large firms suddenly become a lot more small firms? Why would not the big company that is paying 7.9 percent spin off the janitorial services and secretarial services or whatever the lower income into a separate entity that would then only have a 3.5 percent cap?

Dr. REISCHAUER. As I mentioned before, I think that the limits that the proposal places on small, low-wage firms are going to gradually fade out of the system simply because the levels are not indexed. Then every firm will face either a flat amount——

Senator BRADLEY. How long a time would you say that?

Dr. REISCHAUER. Oh, 20 or 30 years.

Senator BRADLEY. Twenty or 30 years.

Dr. REISCHAUER. Your point is quite valid, and we have discussed it at some length in the chapter on economic effects, in our report. There will be a group of firms that face this 7.9 percent-of-payroll cap, and, in effect, the premium payments for them are equivalent to a payroll—dare I say the word—"tax."

The other firms basically will be paying a head tax—just a flat premium amount. We have assumed that precisely what you have described will happen—that lower-wage employees will tend to group together in firms that are at the low end of these caps—and that that clustering would have a dramatic impact on the cost of the program.

Senator BRADLEY. All right. Then that leads to my second question, which is unrelated to health care, but related to the individual who is receiving the benefit. If you are an individual spun out into this new firm that now covers your health care with this cap, what impact might that have on your pension? I mean, you have a different entity now that is responsible.

Dr. REISCHAUER. The way we should look at the economic changes of this sort that are likely to occur is not that Company A will necessarily say: "Let us take all of our low-wage employees and spin them off to another company that we set up." Instead,

serviced firms—janitorial services, lawn care services, all low-wage services—will grow faster, and employment in them will grow faster. As more service firms are set up, more companies will buy services of this sort on the outside.

To a certain extent, these changes are going on now. If you run a large corporation that provides generous pension and health care benefits under existing laws and you can spin off your janitorial group and hire a janitorial service, you gain a tremendous advantage because you do not have to pay any health costs or pension costs. The average small firm that provides those kinds of services does not provide those kinds of benefits.

Senator BRADLEY. Just let me say that is one of my concerns, that we do a reform that spins people off and accelerates a process that is already underway. Part-time employment is another variation of that. It ends up with everybody getting health care, but ending up in companies, small companies, that essentially do not give many pensions.

So I think that we have to look at the total security framework here, not just simply the health care framework.

Dr. REISCHAUER. I agree that that is pretty important.

Senator BRADLEY. Now the next strain of revenue that comes in is from the Federal Government. That is for the small business, low income, et cetera. You estimate that that entitlement cap will be hit in, what, 1997?

Dr. REISCHAUER. I think 1997, the second year out.

Senator BRADLEY. At which point after 2 years what are the options? I mean, it seems to me that one option is, you are either going to have to find revenue some place and increase somebody's payment into it, a tax or whatever. The other is, you are going to have to cut benefits. Or the third is, you are going to have to increase the deficit. Are there any other options?

Dr. REISCHAUER. I think that is the whole list.

Senator BRADLEY. So that 2 years after we do this reform we are going to be confronted with these questions—increased taxes, increased deficit or reduced benefits. The question occurs to me: Why do we not face that up front rather than 2 years from now?

Dr. REISCHAUER. Our sets of numbers assume that what you do is take a walk—that is, just say that we will raise the deficit. If we had assumed that the caps were effective—which, legally, we do not think to be the case—then the costs we estimated for the administration's proposal would have been much lower and the impact on the deficit much less than we have anticipated.

Senator BRADLEY. So that the increase in the deficit that you attribute in your analysis is because the caps basically are reached in 2 years?

Dr. REISCHAUER. We built the ineffectuality of the caps into our estimates.

Senator BRADLEY. Thank you.

The CHAIRMAN. Thank you, Senator Bradley. Regarding that question of unanticipated consequences on pensions, Dr. Reischauer's report, of course, raises just that general point.

And now for the last of our first round, Senator Pryor.

Senator PRYOR. Thank you, Mr. Chairman. Mr. Chairman, I am very proud that you have called this hearing today because I think

it give us a real opportunity to reflect on what Dr. Reischauer and his very competent staff actually said in their report.

I am reading headlines from newspapers—The Washington Post, The Wall Street Journal, The New York Times, et cetera—and many of these headlines, not necessarily the stories, but the headlines, indicate that CBO is coming out and just pillaring the Clinton plan. But the more I look into the report, the more I read of the very fine report given to us by CBO, notwithstanding some areas where Senator Rockefeller and Senator Riegle have pointed out that may not have been fleshed out, I think that there is a lot of what you are saying about this plan that is very positive.

I would like to ask this question. You stated: "Focusing on the effects of the proposals in their early years is therefore not very meaningful. It is the long term impact when new coverages would be fully phased in and the system stabilized that are important." I think that is important.

I think that you have poignantly pointed up this belief that you have and you have given a great deal, I think, of credibility to the so-called Clinton plan.

I think the question I would have at this point, where all of the papers seem to be saying that there is a vast difference in cost estimates that you are coming up with, I am reading in this report—and I hope I am reading it correctly—is saying that the overall financing of the Health Security Act is sound.

And in your opinion, if I might ask this question, could relatively modest changes in the Health Security Act make it deficit neutral in the next 5 years? Are there some ways to neutralize this first five year deficit increase that you are looking at which would not be of major consequences?

Dr. REISCHAUER. Whether the consequences would be major or not is a decision for you to make. You could scale back the benefit package. You could reduce the generosity of the subsidies in the system. You could increase the Medicare and Medicaid savings. There are a number of things that could be done.

The differences between the administration's numbers and ours are not large relative to the menu of options that people have. But at the same time, implementing some of those options might be extremely difficult politically. That is not my area of competence; it is yours. We at CBO stand ready to estimate any variant of this plan or other plans that are presented to us by the committees of the Congress.

Senator PRYOR. A new report from yesterday says that Mr. Reischauer went out of his way to call the differences in financial estimates "relatively small potatoes in the great scheme of things." That is your quote?

Dr. REISCHAUER. Yes, I was looking for honorary citizenship in the State of Idaho. [Laughter.]

Actually, in Maine. I should correct that.

Senator PRYOR. I think you made your point. You made your point very well.

Another point I think that the analysis states, and I quote: "The CBO analysis is a significant acknowledgement that health reform can do what is necessary. That is provide health coverage for all

Americans while containing skyrocketing health care costs." That is a statement from the report, is it not?

Dr. REISCHAUER. Yes.

Senator PRYOR. I think, Mr. Chairman and Mr. Reischauer, there are a lot more similarities that need to be identified. I look forward to working with CBO. I definitely look forward to your reports within the same degree of scrutiny on the other, alternative plans.

I was out of the room. Did you state when these reports might be available for us?

Dr. REISCHAUER. I said that we were looking for guidance from the bipartisan leadership of the Congress as well as from the chairmen and ranking members of the relevant committees on which items we should turn our attention to next.

There are far more proposals on our desks waiting for analysis and for more requests for cost estimates than our office has the capacity to complete in the near future.

Senator PRYOR. Thank you, Dr. Reischauer.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, sir. May I just say he also said work would go forward after those people in the front row have one weekend off.

I have just a very brief question, sir. First of all, just to clarify what might have been understood. You never said that health costs as a proportion of GDP will decline under the bill. You mean they will decline relative to the current track.

Dr. REISCHAUER. Correct. Senator Durenberger is the proponent of 10 percent of GDP for health care, not the Congressional Budget Office.

The CHAIRMAN. That is his plan. Right.

Dr. REISCHAUER. Well, that is his plan before we have costed it. [Laughter.]

The CHAIRMAN. We will just leave that. And on this matter that Senator Pryor pointed out, why do you not tell us where you think in your judgment we would most need to apply your resources. What plans we have are different enough that we really——

Dr. REISCHAUER. I would like to discuss this with my staff, and then we can sit down together and set up an agenda.

The CHAIRMAN. All right. Sure. After that famous weekend off.

But one last question. On page 50 in your report you state, and I quote: "If the Congress decided to include the income and outgo of the alliances in the Federal Government's accounts, it could facilitate their recording and control by requiring them to flow through the Treasury."

Would you expand on that just a bit? What are the advantages of requiring the monies to go through the Treasury? I think that perhaps is your most specific recommendation.

Dr. REISCHAUER. No, this is pretty far down the list. If the monies went through the Treasury, we would have some accurate estimates of what the financial flows really were. As you know, the United Mine Workers Benefit Fund is a Federal Government activity and is so viewed by both the Congressional Budget Office and the Office of Management and Budget.

The CHAIRMAN. Recorded I believe as a "T."

Dr. REISCHAUER. Excuse me?

The CHAIRMAN. Recorded as a "T," scored as a "T."

Dr. REISCHAUER. No, scored as an "R." It is a receipt, one of the miscellaneous receipts on the receipts side of the budget, nestled in there beside the earnings of the Federal Reserve.

Where was I? [Laughter.]

Senator PRYOR. Somewhere between T and R. [Laughter.]

The CHAIRMAN. And in West Virginia.

Dr. REISCHAUER. Those funds, which are paid by coal companies to a trust fund operated by private trustees, are Federal receipts and the benefits are Federal outlays, but they do not flow through the Treasury.

As a result, the monthly Treasury statement, by which we keep track of Federal flows—or at least most large Federal flows—does not record those amounts. It records them only at the end of the year.

Now, for an activity that involves between $200 million and $300 million, this omission may not be the most egregious one in the world. But for governmental activity that would involve between $500 billion and $700 billion, that is not the case.

The CHAIRMAN. A fair point. Would you want to offer—maybe this is just too much to ask—what assumptions you would make about the ability of alliances to enforce payment requirements on employers and individuals. They will have a lot of that.

Dr. REISCHAUER. We raised that issue in our fifth chapter as one of the things that you should be concerned about. I do not think that our expertise on that topic extends much beyond the few sentences we have there.

The CHAIRMAN. Absolutely fair enough, sir. I quite thank you.

Now, Senator Packwood.

Senator PACKWOOD. I have no further questions.

The CHAIRMAN. Well, there is 10 percent Durenberger down the line there.

Senator DURENBERGER. Mr. Chairman, thank you.

Bob, I would like to end up asking you a question or two. But let me premise it by saying a couple of things I have taken out of this hearing today. One of them is the President's goal is to increase health spending to 19 percent of the GDP in 10 years. I cannot tolerate that. The American people cannot tolerate that.

Dr. REISCHAUER. I do not think that is the goal of the President. I think the goal is to slow down the freight train we are on right now. Slow it down—but maybe not as much as you would wish.

Senator DURENBERGER. All right. Let me restate it. The effect of all of the President's goals as articulated in his plan, as interpreted as of 2:00 a.m. the morning before last by the Congressional Budget Office, is that this country if it launches on this 800 movable parts plan, which very few people can understand, and which may be in trouble because of that, is going to cause radical change in the way we buy and pay for health care in this country.

And all we get for it is approximately a 1 percent savings in the rate of growth.

Dr. REISCHAUER. It would be 1.1 percent of GDP.

Senator DURENBERGER. Yes.

Dr. REISCHAUER. Reduction.

Senator DURENBERGER. We are going up from an expenditure today of under $1 billion. We are going to go up to a little over $2 billion.

The CHAIRMAN. You mean trillion.

Dr. REISCHAUER. Trillion.

Senator DURENBERGER. Trillion, yes. Even after 16 years it gets hard with all the——

Dr. REISCHAUER. A hundred billion here, a hundred billion there.

Senator DURENBERGER. I am not going to argue the point with you because I am using your words. But I think people need to understand that that is all the President's plan for all of its complication and all of its debate is giving us.

It is giving us 19 percent of GDP for $2 trillion in spending in this country 10 years out and 10 years of all of this adjustment and everything else.

And as someone who has been at this now for 15 years, let me say that when the problem is that it costs too much today. And it is not just the inequities in the system, which all of us can talk about. The crisis is real. The President is right and the crisis is not just in the uncovered. The crisis is what all of us are paying and what all of us are getting.

You said rightfully that you cannot estimate quality. You have not gone into the inefficiencies in the current system. But I must say to you, Bob, you must. Somebody must.

When you said that is his plan before we costed it, I understood you earlier today in a response to Jack Danforth's question to in effect say, you have already costed our plan or you have——

Dr. REISCHAUER. No, no.

Senator DURENBERGER. You have costed a part of plan which is in Clinton, which is the alliances and the basic benefit packages and so forth.

Dr. REISCHAUER. No. We did an estimate of the Cooper plan—I do not know if it was Breaux—Durenberger at that point.

Senator DURENBERGER. Right.

Dr. REISCHAUER. It was the Cooper plan that was introduced in the 102d Congress. That plan has been changed. We have not estimated the changed plan, but, once again, it is high on the agenda for our discussion with the bipartisan leadership.

Senator DURENBERGER. But what I heard you say in response to Jack's question is, that the Clinton plan without price controls, but with alliances, with accountable health plans, with a basic benefit package as described there and so forth, if it does not have the price controls you in effect have discredited the other things that are in there that are designed to bring markets to bear at the local market level across the country.

Dr. REISCHAUER. No. I think you misinterpreted what I said completely.

Senator DURENBERGER. Well, then clarify it then.

Dr. REISCHAUER. The tax disincentive in the administration's proposal is extremely weak compared with the one in the plan that you are talking about, the early Cooper plan. I was referring to the effect of keeping everything else in the administration's proposal the same but removing the premium limits. Then we would have

very small teeth in the tax area. It is not the 34 percent excise tax that the Cooper plan has in it.

Senator DURENBERGER. Well, then maybe I might make a suggestion. I will not take the time to go into the existing markets and ask you questions about in-patient hospital days to demonstrate that some markets do work in this country and so forth.

But I think one of the more valuable suggestions that has come out of this hearing today is that whether we do it around the response to Alain Enthoven or we do it around something else, that it would be very helpful for a group of us to help you and your staff get some direction for the next couple of months on what it is you ought to be estimating.

The CHAIRMAN. Yes.

Senator DURENBERGER. From my standpoint, I do not think it is worthwhile estimating plans. I mean, you can forget about estimating our plan as an offer and forget about estimating the rest of the plans. I think we need to agree on what it is that is beginning to work in America today. What of behavior change did the Clinton bill anticipate when it went into alliances, and accountable health plans, and the function of a basic benefit and a tax cap, and things like that.

Dr. REISCHAUER. I think at the same time we want to avoid viewing one-time savings that we might be able to wring out of the system as an indicator of what we can do over the long run. Our current system may have a lot of inefficiency, may provide a lot of unnecessary care, that we could squeeze out of it. But there is no evidence that administrative costs, inefficiency, or inappropriate procedures have been a growing portion of our national health care bill.

If you could wring out all of those unnecessary costs, what you would do is lower the level of spending. You would not change the rate of growth. And if the rate of growth is being determined by other factors, you still have to confront those factors.

Senator DURENBERGER. Right.

Mr. Chairman, I do not want to belabor the point. It is really appropriate, in fact it is critical, that a definition of managed competition distinguish between the one-time savings. Because all the talk about paperwork and administration is strictly one-time saving and it is not going to do it for you.

What we are talking about is changing behavior. The inefficiencies in the current system, the over utilization of hospitals and technology and all the extra surgeries that are performed and God knows what, we could spend forever on it. Changing the way medicine is practiced in this country by changing the way we buy those services is what we need to start measuring on the basis of what is already going on in communities in this country that are way below the so-called national average for health care costs.

I hope that that is the endeavor that we can get some commitment of time on.

The CHAIRMAN. May I say, Senator Durenberger, that Senator Packwood and I think it would be useful just to meet in our back room with you, Dr. Reischauer, and sort out what your capacities are, what you think the priorities ought to be.

Senator Durenberger has given a very important conceptual suggestion that we talk about practices and innovations in medicine as against this statute or that statute.

And with that, sir, Senator Pryor.

Senator PRYOR. If I could have just 2 minutes, Mr. Chairman. I appreciate this. I know that we have to leave.

But I was leaving the room awhile ago and my good friend Senator Durenberger asked the question, well, wait a minute, what are we getting for all this if we go to 1 more percentage point or save 1 percentage point of the GDP. There is something I think we ought to start thinking about, and I elicit this from the significant study offered by Mr. Reischauer.

One, the Clinton plan when compared to today's system would cost the average American less money. That is one thing we are getting from it. Give them more health benefits and more choice of physicians and medical care. I think those are significant, Senator Durenberger.

Again, on page 26, once the administration's proposal was fully implemented it would significantly reduce the projected growth of national health expenditures. That is something else we are getting for it.

I think going back here, once again citing the proposal, but business's costs for health care would be significantly reduced, a reduction in business costs. We could go on and on. I think there are several things as we say we might be getting for the cost of the Clinton health plan.

I look forward to discussing those at another time with my friend and colleague Senator Durenberger. But I could not let his assumption rest without some degree of challenge that we are not getting anything for the new plan.

But I thank you, Mr. Chairman, for allowing me to get that straight.

The CHAIRMAN. We thank you. And so it falls on me to express first of all the committee's great appreciation to Paul Van de Water, to Linda Bilheimer, to Douglas Elmendorf, and to Douglas Hamilton for their work in the chapters that we have had.

And most particularly to you, sir. You have been faultlessly forthcoming and clarifying witness. We are much in your debt and we will continue to be as Senator Durenberger and others have suggested. But we do urge you to get that weekend off. All right?

With that, the first part of our agenda is concluded.

[Whereupon, at 12:48 p.m., the hearing was adjourned.]

[The prepared statement of Senator Grassley appears in the appendix.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED

PREPARED STATEMENT OF SENATOR DAVE DURENBERGER

Mr. Chairman, thank you for holding this hearing today. I am looking forward to what Mr. Reischauer has to tell us about his analysis of the President's Health Security Act.

Like all my colleagues on this committee, I am interested in CBO's recommendation that government-mandated health insurance premiums should be included in the federal budget. I believer however, that a debate focused on whether the plan is "on budget" or "off budget" misses a larger point. However the premiums are labeled, under the President's Health Security Act they will become public money.

The way the President's plan is structured, private insurance purchased by private citizens or firms will be converted into public goods. This is not in the best interest of most Americans and not the way this committee should approach comprehensive health reform. Government should set the market rules and not make private transactions part of the public fisc.

Mr. Chairman, the Congressional Budget Office tells us that the President's proposal must rely on premium caps and Medicare cuts as the basis for it's long term savings. This points to the more fundamental problem with the Health Security Act. That is, although the plan is wrapped in the appearance of using the market to efficiently allocate health care resources, it actually depends on regulation to control costs.

We have abundant evidence in this country to show that premium caps or global budgets have not worked and will not work. Caps always mean more regulations to meet those budgets and also mean that rationing of some form develops to obtain the regulated good. At the end of 1993, hospitals in Canada actually closed their doors because budget limits were exceeded. More regulations and waiting lines are not what health reform should create.

The only effective way to get costs under control is by making the currently dysfunctional health care markets work. Competitive markets will change the practice of medicine by rewarding providers who offer high-quality care at the lowest possible price.

My belief is not based on theories or speculation. It is based on the facts of the Minnesota health care market today. Minnesota has developed many of the essential conditions for a sound market and currently uses important elements of managed competition.

As I have shown both this Committee and Mr. Reischauer, during his visit to Minnesota last February, managed competition is working in Minnesota. Managed competition saves money by improving people's ability to choose cost-effective health care providers. The federal government says to providers, we will give you a fair playing field to compete, but you have to win the game yourselves.

The Twin Cities in my state have a competitive health marketplace. Health plans compete for patients, and businesses—the primary payers of health care—negotiate with health care providers to obtain low-cost care for their employees.

Competition is so successful in the Twin Cities that health costs are only 82 percent of the national average. The Twin Cities' small employers pay 15 percent less for the most comprehensive indemnity plan. And, these costs are lower in a state where 92 percent of its residents have health insurance coverage. I say this evidence proves managed competition works to expand access to care and to reduce health care costs.

In CBO's recent work, it determined that managed competition—or competitive markets—do not reduce health costs. If markets do not reduce health costs, I must

ask how can Minnesota's experience be explained? Costs are not controlled in a vacuum. Businesses and providers in Minnesota have attempted to address many of the problems with the dysfunctional health care market. Unfortunately, however, without national rules.

Mr. Chairman, another recurring issue—which you and I have discussed—is the inability of CBO or OMB to estimate the effect a reformed marketplace will have on individual behavior. Yet, comprehensive health reform is all about behavior changes at the provider, consumer and government levels.

I'm especially concerned about CBO's analysis last November in a report entitled, "Behavioral Assumptions for Estimating the Effects of Health Care Proposals." Their analysis indicated that people do not seek out cost-effective care from low-cost health plans.

This is problematic because CBO's conclusion contradicts what is happening in practice in my state and the results of the study, completed by University of Minnesota researchers, upon which the CBO conclusion was based. The University of Minnesota researchers and Stanford University's Dr. Alain Enthoven wrote to Mr. Reischauer to describe the mistake in CBO's analysis. I request to include these two letters in the hearing record. I hope Mr. Reischauer will explain how his organization came to its seemingly contradictory conclusion.

Mr. Chairman, I am looking forward to hearing CBO's conclusions about the Health Security Act. I believe that Mr. Reischauer's report will be an important part of the debate this Committee and the Congress will be undertaking over the next several months.

Attachments.

UNIVERSITY OF MINNESOTA

Twin Cities Campus

Institute for Health Services Research
School of Public Health

Box 729
420 Delaware Street S.E.
Minneapolis, MN 55455-0381
612-624-6151
Fax: 612-624-2196

January 4, 1994

Sandra Christensen, Ph.D.
Congressional Budget Office
Second Avenue and D Streets, S.W.
Washington, D.C. 20515

Dear Dr. Christensen:

Your recent study "Behavioral Assumptions for Estimating the Effects of Health Care Proposals" (November, 1993), summarizes the results of several studies, including ours, which estimate the premium-price elasticity of health plan choice. In the introduction to the section containing our results, you state the "...the results may be interpreted as responses to price changes among competing plans ..."(page 9). Clearly, your intent is to estimate the impact of a health plan's decision to raise or lower its premium. Yet, when you calculate the elasticities shown in Table 3, page 10 you do not use the health plan's choice variable, its full premium, as the base for calculating the elasticity. Instead you use a variable over which the health plan may have little or no control, the employee's out-of-pocket premium, as the base. The results in Table 3 thus not only reflect a logical inconsistency, but also mask a crucial factor which determines the size of premium elasticities: the way in which the employer (or government's) contribution to premiums is set.

The numerical effect of this inconsistency is enormous, resulting in calculated elasticities that are off, *minimally*, by a factor of ten. For example, the elasticity that you refer to as "same-type switch" for a health plan that has fifty percent of its "nest" should be -8.693, rather than -0.523.

We have attached a brief explanation of this point. Please note also that your "HMO/FFS" switch elasticities based on our study are incorrect, even using your approach. We hope you find this information helpful and will contact us if you have any questions.

Sincerely,

Roger Feldman, Ph.D.
Professor

Bryan Dowd, Ph.D.
Associate Professor

Calculating Premium Elasticities of Health Plan Choice

Roger Feldman and Bryan Dowd
Institute for Helath Services Research
University of Minnesota

January 10, 1994

The general expression for any elasticity is $\frac{\partial Q}{\partial P}\frac{P}{Q}$ or the percentage change in Q associated with a percentage change in P. In the case of health plan choice, Q is some measure of the quantity of enrollment (number of enrollees, or equivalently, market share, assuming the number of *total* enrollees to be divided among health plans is held constant) and P is the health plan's premium.

In the conditional logit model which was used to derive our estimates [1], the probability of choosing the j^{th} health plan is a function of characteristics of health plans, including the health plan's premium. The probability of choosing one health plan versus another is a function of the employee's out-of-pocket premium *differential* between the two plans. To estimate the effect of an increase in the health plan's premium on the health plan's enrollment, one must first know how a $1.00 increase in the health plan's *total* premium (P_{TOTAL}) affects the out-of-pocket premium differential (ΔP_{OOP}) between that plan and other plans in the employee's "choice set". In other words, in order to capture the potentially important difference between the health plan's total premium and the consumer's out-of-pocket premium differential (which determines choices of health plan), the formula for the elasticity must be rewritten as:

$$\left[\frac{\partial Q}{\partial \Delta P_{OOP}} \times \frac{\partial \Delta P_{OOP}}{\partial P_{TOTAL}}\right]\frac{P_{TOTAL}}{Q}$$

The derivative $\partial \Delta P_{OOP} / \partial P_{TOTAL}$ depends on the way in which the employer's (or government's) contribution to premiums is set. There are two examples of primary interest: a "defined" or "fixed"contribution to premiums set equal to, or less than, the lowest health plan's total premium and a fixed *percentage* contribution. In the case of a defined contribution, any health plan that raises its premium $1.00, *ceteris paribus*, will *reduce* the out-of-pocket premium differential (ΔP_{OOP}) between itself and higher cost plans by $1.00 and *increase* the premium differential between itself and lower cost plans by $1.00. The effect

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[1] Feldman, Roger, Michael Finch, Bryan E. Dowd, and Steven Cassou. "Demand for Employment-Based Health Insurance Plans," *The Journal of Human Resources* 24:1 [Winter, 1989] pp. 115-142)

of both types of changes will be to decrease the higher cost plan's market share.

In the case of the level dollar contribution, set at or below the lowest total premium, $\partial \Delta P_{OOP} / \partial P_{TOTAL} = 1.0$. This is true of the employer contribution in Clinton's proposal.[2] Thus, the correct expression for the total elasticity is simply $\left[\frac{\partial Q}{\partial \Delta P_{OOP}} \times 1.0\right]\frac{P_{TOTAL}}{Q}$. But notice that the correct "index" value of P is P_{TOTAL} *not* P_{OOP}.

Alternatively, suppose that the employer pays 80 percent of the premium of all plans. In that case, ΔP_{OOP} is $[P_A - [P_A \times .8]] - [P_B - [P_B \times .8]]$ and the derivative of this expression with respect to P_A is .20 and the correct formula for the elasticity is $\left[\frac{\partial Q}{\partial \Delta P_{OOP}} \times .20\right]\frac{P_{TOTAL}}{Q}$ but again, the correct "index" value of P is P_{TOTAL} *not* P_{OOP}.

Before noting the effect of using the correct index value of P, it is necessary to clarify some terminology. In our results, we found two types or "nests" of health plans in the nested multinomial logit model: plans which allowed relatively unrestricted access to a large number of participating physicians, and those that didn't. The term "same type switch" in the CBO report must refer to "within-nest" switch when used in reference to our study. Similarly, the "HMO/FFS" elasticity must refer to a "cross-nest" switch. We understand the difficulties associated with combining the results of several studies into one report, and we assume that CBO understands and would agree with this clarification.

For "same-type" or "within-nest" switches, the correct prices elasticities would be given by the following formula, taken directly from the discussion above: $(\partial Q_{j|i} / \partial \Delta P_{OOP}) \times (\partial \Delta P_{OOP} / \partial P_{TOTAL}) \times (P_{TOTAL} / Q_{j|i})$. Note that $\partial Q_{j|i} / \partial \Delta P_{OOP}$ is just $\beta \times Q_{j|i} \times (1 - Q_{j|i})$ where β is -.00278 from our *JHR* paper and $Q_{j|i}$ represents the quantity or market share of enrollees in the j^{th} health plan in the i^{th} nest. We use the sample mean value of P_{TOTAL} which was $62.09 or 6,209 cents (not reported in the *JHR* paper). The numbers and calculated values for $\partial \Delta P_{OOP} / \partial P_{TOTAL} = 1$ (level dollar contribution) are shown in the table below:

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[2] In the Clinton administration's proposal, the employer's contribution is set at 80 percent of the weighted average premium, where the weights, presumably, are the plans' market shares in the prior year. Consider the case of two health plans with total premiums denoted P_A and P_B. The difference in out-of-pocket premiums (ΔP_{OOP}) is:

$[P_A - .8 [P_A Q_A + P_B Q_B]] - [P_B - .8 [P_A Q_A + P_B Q_B]]$ where Q_A and Q_B represent the prior year market shares. The derivative of this expression with respect to $P_A = 1.0$.

Table 1: "Same-Type"or "Within-nest"elasticities

$Q_{j\|i}$	$\partial Q_{j\|i} / \partial \Delta P$	$P_{TOTAL} / Q_{j\|i}$	"Same-type" Elasticity	
			(Our estimate)	(CBO estimate)
0.5	-.00070	12,418.0	-8.631	-0.523
0.6	-.00067	10,348.3	-6.904	-0.418
0.7	-.00058	8,870.0	-5.178	-0.314
0.8	-.00044	7,761.3	-3.452	-0.209
0.9	-.00025	6,898.9	-1.726	-0.160
1.0	--	--	--	--

The table shows that the corrected elasticities are dramatically larger in absolute value than CBO's original estimates. To calculate the corrected estimates for a level percentage contribution system, the numbers in the fourth column should be multiplied by one minus the employer's level percentage contribution. For example, the correct elasticity in a system in which the employer contributes 80 percent of a health plan's premium, calculated at $Q_{j|i}$ = .5 would be (1-.80) x -8.631 = -1.726 .

The second type of elasticity is the "cross-nest" elasticity, which can be written as:

$$\frac{\partial Q_k}{\partial \Delta P_{OOP,j,i}} \times \frac{\partial \Delta P_{OOP,j,i}}{\partial P_{TOTAL}} \times \frac{P_{TOTAL}}{Q_K}$$

where k represents the k^{th} "nest" or type of health plan and $P_{OOPj,i}$ is the out-of-pocket premium of the j^{th} plan in the i^{th} nest. Since there are only two nests, $Q_k = 1-Q_i$ and thus $\partial Q_k / \partial P_{OOPj,i} = -\partial Q_i / \partial P_{OOPj,i}$ and is shown in the *JHR* paper to equal $-\beta\lambda Q_{j|i}(1-Q_i)$ where β = -.00278, as before, and λ = .304, the coefficient on the "inclusive value" from our JHR paper. Interestingly, the cross-nest elasticity, calculated at Q_{ij} = 0.50, turns out to be a constant for all values of Q_i ranging from .5 to 1.0 and the correct value is 2.62. Notice that this elasticity is positive, as it should be, since raising the price of a plan in one nest will increase the market share of the other nest.

PREPARED STATEMENT OF SENATOR CHARLES E. GRASSLEY

Thank you, Mr. Chairman.

Dr. Reischauer, I would like to thank you for a very helpful report. I particularly would like to thank you for a very useful discussion of the appropriate budgetary treatment of the President's plan, were we to enact it.

It seems to me that you struck just the right note in clarifying the nature of President's plan from a budgeting perspective, and in recommending that the financial transactions of the health alliances be included in the Federal Government's accounts, and the premium payments shown as governmental receipts rather than as offsets to spending. I also agree that it is really the responsibility of the President and the Congress to determine more specifically how we will treat the program—for instance, how it should be treated for purposes of the pay-go rules.

Beyond that, it seems to me that your discussion in chapter three is particularly enlightening as to what kind of plan we are talking about.

I won't belabor the point here, but will just observe that, if anybody was under the illusion that this is not a completely public, and completely federal, take over of the health care system, they could not have been after reading that chapter.

Second, I would like to say that I am grateful that you have been candid about the limitations inherent in the kind of analysis you and your staff have provided us. As you noted, any such analysis of a proposal calling for such massive and comprehensive changes in a major institutional sector, regardless of who does it, is vulnerable to wide variations in estimates, depending on the assumptions on which the estimates are based.

I would remind members of the committee and those who are watching that the $500 billion 1990 deficit reduction package has had about $190 billion of upward technical revisions since it was passed. And this is not quite 4 years later.

The Lewin-VHI analysis of the Clinton plan conducted a kind of sensitivity analysis which used three different assumptions about six different features of the bill.

Just by way of example, they estimated that, if the premium growth limit were increase[3] by 1.5 percent, the net change from their best estimate of the cumulative budget depict for the period 1995 to 2000 would be $42 billion dollars. With respect to the treatment of health benefits under cafeteria plans, they found a swing of around $34 billion over that period when they used different assumptions.

None of this is news to the people who make a living by making such estimates. And I dare say none of it is news to members of this committee.

My point here is that, for a proposal as complex and comprehensive as that proposed by the administration, we can estimate until we are blue in the face, but will still be making a leap into the dark as far as really knowing what the financial consequences are going to be. The actual performance of the Clinton plan, if enacted, could be much better than even the President's estimators believe. Or, It could be much worse than CBO and other estimators believe.

I don't mean to suggest by this point that we should not do our best to improve the way our health care system works. I do mean to imply that the more comprehensive and complex the plan we adopt, the more risky will be the endeavor, for a number of reasons, including the possibility that estimating errors will be so much larger.

PREPARED STATEMENT OF ROBERT D. REISCHAUER

The Health Security Act is a comprehensive proposal to provide a universal entitlement to health insurance for a broad range of services and to slow the growth of spending for health care. To achieve these goals, it would fundamentally restructure the current health care system, changing requirements and incentives for employers, consumers, insurers, and providers of care. Because of the magnitude of these changes, the full—impact on the health care system is extremely difficult to predict.

The Administration's proposal would redesign the current system of financing for health care, while building on its existing employer base. All employers would be required to pay premiums on behalf of their employees, and all individuals and families—except Medicaid beneficiaries and others with very low income—would be required to pay at least part of their premiums. Subsidies would be available to help employers and low-income families meet these obligations and would also be available for retired people ages 55 to 64.

To strengthen the demand side of the health care marketplace, the proposal would establish regional purchasing alliances through which most people who worked for firms with 5,000 or fewer full-time employees would obtain health coverage, as

would most other people under age 65 who had no connection to the labor force. Larger firms, firms participating in multiemployer group plans, rural electric cooperatives and telephone cooperative associations, as well as the U.S. Postal Service, would be entitled to establish their own corporate alliances. Medicare beneficiaries would generally remain outside the alliance system. States could choose to opt out of the regional alliance system entirely and establish a "single-payer" system of health care financing, in which the state would pay all providers directly.

Consumers would normally have access to a choice of health plans of different types—including at least one fee-for-service plan—that would be offered through the alliance in the area in which they lived. All plans would offer a standard package of benefits, which would be slightly more generous than the average plan currently offered by employers. To ensure that consumers could make informed choices about those plans, alliances would provide much more information about the plans they offered than is typically available today.

The primary objective of the proposal is to ensure that health coverage would be available at a reasonable price to everyone and that people could not be denied coverage because of their health status. Accordingly, strict requirements would be placed on the enrollment procedures that health plans could employ, requiring plans (within the limits imposed by their capacity and financial constraints) to accept all applicants, and prohibiting plans from excluding people because of preexisting medical conditions. A plan's premiums could not vary for any reason other than the type of family being insured, a requirement known as community rating. (Premiums for plans offered by corporate alliances could, in addition, vary among geographic areas.)

People entitled to Medicaid benefits because they also receive cash welfare payments would continue to obtain coverage from Medicaid but, like almost everyone else, would be enrolled in health plans offered through the regional alliances. Others who currently receive Medicaid benefits would lose that coverage, but most of them would be eligible for subsidies for their premiums.

The proposal would also expand several federal programs and institute new ones. Important among these provisions are coverage of prescription drugs for Medicare beneficiaries, the provision of "wraparound" health care benefits for low-income children, and a new program to provide home- and community-based services for severely disabled people.

Financing for these initiatives and the subsidies that the federal government would pay to alliances would come from a variety of sources. They would include several new revenue measures, increases in income and payroll tax receipts generated by the change in the mix of employee compensation that would occur under the proposal, reductions in the Medicare and Medicaid programs, and assessments on premiums. States would also make maintenance-of-effort payments to alliances, reflecting their reduced obligations for Medicaid under the proposal.

To lower the rate of growth of health care spending, the proposal would establish a complex mechanism for limiting the growth of premiums for the standard benefit package—an approach that, if carried out as intended, would almost certainly be effective on that score. The proposal would also attempt to limit the obligations of the federal government for subsidy payments, but that endeavor would be less likely to succeed.

UNCERTAINTY OF THE ESTIMATES

Estimates of the interactive effects of so many complex changes to an industry that encompasses one-seventh of the economy are highly uncertain. Assumptions, used by the Congressional Budget Office (CBO) and other analysts, about people's behavioral responses to new incentives are frequently based on research evidence from small changes in the existing marketplace. In the case of the Administration's proposal, however, the entire marketplace and the configurations of the actors within it would be changing, and there is no precedent for estimating the effects on health spending or the economy.

Estimating the effects of any proposal to restructure the health care system is particularly difficult because, inevitably, the transition from the old to the new system would take several years. Focusing on the effects of proposals in their early years is, therefore, not very meaningful; it is the long-term impacts, when new coverages would be fully phased in and the system stabilized, that are important. Unfortunately, the uncertainty surrounding cost estimates increases significantly in the out-years. Thus, although CBO believes that the most important estimates presented in this paper are those for 2004, they are also the most uncertain.

FINANCIAL IMPACT OF THE PROPOSAL

National health expenditures would rise in the initial years of the Administration's proposal—an inevitable consequence of expanding health insurance coverage to the uninsured, increasing the generosity of the benefits that many insured people currently receive, and expanding home- and community-based services for the disabled. Over time, however, the combined effects of lowering the rate of growth of health insurance premiums and the cuts in the Medicare program would dominate. Thus, CBO projects that national health expenditures would fall $30 billion below the current CBO baseline by calendar year 2000, and would be $150 billion (7 percent) below that baseline in 2004.

The effects on the federal budget deficit show a similar pattern. The increase in the deficit is estimated to reach slightly more than $30 billion in 1998, the first year in which all states would be participating in the system, and then begin to fall. It would rise again in 2001 and 2002 because of two additional factors in those years: increases in the generosity of the standard benefit package that would occur in 2001, and the subsidies, beginning in 2002, of state and local governments in their role as employers. By 2004, however, the estimated effects on the deficit are negligible, and CBO believes that the proposal holds the promise of reducing the deficit in the long term.

CBO's estimates of the effects of the proposal on the deficit differ only modestly from those of the Administration. Because the Administration developed estimates for the 1995-2000 period, comparisons for the out-years, which are more important, cannot be drawn. For the six-year period from 1995 through 2000, though, the Administration's estimates indicate that the proposal would reduce the deficit by about $60 billion. In contrast, CBO estimates that the deficit would increase by more than $70 billion over that period. The difference between these estimates is small, however, compared with the uncertainty surrounding the budget projections.

The primary difference between the two estimates stems from the amount of subsidies for employers, with CBO's estimate being considerably higher than the Administration's—by $25 billion in 2000, for example, or about half of the difference in the estimates of the effects on the deficit in that year. The estimates of subsidies for employers differ for three major reasons. CBO's estimates of pre miums for the standard benefit package are higher than the Administration's, and estimates of these subsidies are extremely sensitive to the estimates of premiums. CBO also assumes that low-wage workers would cluster in firms that received subsidies, a factor not explicitly taken into account in the Administration's estimates of subsidies. Finally, CBO has used a different methodology than the Administration, one that captures more of the variation in average wages among firms.

EFFECTS ON THE ECONOMY

Although the Administration's proposal would make fundamental changes in the current health care system, the overall economic impact of those changes might not be large. Because the proposal would involve substantial redistributions within the economy, however, the impact on business costs and employment might be significant for individual firms and people. Similarly, though the proposal would have little predictable effect on national saving and investment, or on the balance of trade, some businesses could see their ability to compete with foreign firms either improving or worsening.

The proposal would retain much of the current central role of employers in the health insurance system, requiring that a large part of health insurance premiums be paid in the first instance by employers. But businesses' costs for health care would be significantly reduced overall, both because the proposal would provide substantial subsidies to firms and because it would limit the growth of premiums. For example, the total premiums employers pay for active workers would drop by about $20 billion in the year 2000.

Although overall costs would go down, for some employers—particularly those that do not currently offer health insurance—costs would increase. Changes in costs could also be pronounced among firms that currently offer insurance. They would rise for some businesses—especially those with young and relatively healthy work forces—as a result of the provisions for community rating. Conversely, businesses that now face high health care costs—because they are small and have little clout in the insurance market, have older or sicker work forces, or hold substantial responsibilities for retirees—would see lower costs.

Those employers facing an increase in their premiums would probably shift most of the added cost to their workers by reducing cash wages, much as occurs now in firms that offer health insurance. Similarly, employees of firms that would pay less would receive higher wages.

For several reasons, the proposal would also affect people's decisions about whether they wanted to seek work or to stay home. For instance, the proposal would guarantee insurance for early retirees and directly subsidize the cost of that insurance. In other words, older people would no longer have to work simply because they needed access to affordable health insurance. A substantial number would probably prefer the pursuits of early retirement to work, if their health costs were not a concern.

The proposal might also tempt some other workers to leave the labor force. With universal coverage, health insurance would be available even to non-workers—in some cases at no additional cost. And the requirement that employers pay insurance premiums for all workers, whether or not they had coverage through a spouse, would encourage some people to stay out of the labor force, especially when there is already a full-time worker in the household.

In contrast to these voluntary withdrawals from the labor force, fewer minimum-wage workers might be employed, since their employers' costs of compensation would often be much higher. The incentive to hire fewer minimum-wage workers would be mitigated for small, low-wage firms, however, because the proposal would cap their payments for premiums at levels ranging from 3.5 percent to 7.9 percent of their payroll. Moreover, the number of people involved would be small, and the proposed expansion of home- and community-based care would increase low-wage employment.

Other provisions of the proposal would encourage some people to enter the labor force or improve the operation of the labor market. Some Medicaid beneficiaries are currently deterred from seeking work for fear of losing their health coverage. For the same reason, some workers feel locked into their current jobs when they might prefer a different one. The proposal's universal coverage would encourage Medicaid beneficiaries to enter the work force and would end job lock.

Taking together all the provisions that might increase or reduce participation in the labor force, CBO estimates that eventually between one-quarter of a percent and 1 percent of the labor force might prefer to stay home if the proposal was enacted. Correspondingly, gross domestic product (GDP) would also be reduced, though by somewhat smaller percentages. These changes are not large, falling well within the uncertainty of projections of the labor force and GDP over the next decade.

The proposal would have one further effect on the labor market, as the subsidies for small, low-wage firms would encourage firms and workers to reshuffle so that low-wage workers would be largely together in small firms. The incentives for this reshuffling, or "sorting," would be strong. But sorting would also impose two types of economic costs: the cost of disruption as firms reorganized production, and the costs of inefficiency that would occur because the way firms were organized would not be driven solely by production considerations.

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BUDGETARY TREATMENT OF THE PROPOSAL

Ever since the outlines of the Administration's proposal have become known, policymakers and the media have expressed considerable interest in how it would be treated in the federal budget. This issue of budgetary treatment is not unique to proposals to restructure the health care system. Every time the Congress considers or enacts a bill that establishes a new program, the Congressional Budget Office and the Office of Management and Budget must consider whether and how it should be treated in the federal budget. For most pieces of legislation, the call is a relatively easy one. But for some bills, such as major health care reform proposals, some ambiguity and considerable complexity accompany that assessment. In this case, CBO strongly believes that the President and the Congress should address the budgetary treatment of the proposal explicitly through legislation. CBO's role in the decision is strictly advisory.

Certain elements of the Administration's proposal are unambiguously federal activities that all agree should be included in the budget—for example, the increase in the tax on tobacco, the subsidies for individuals and employers, the expansion of certain discretionary programs, and the changes in Medicare and Medicaid. But what about the premiums that individuals and employers pay to the health alliances and the payments by alliances to health plans? Are the alliances private or

state entities that belong outside the federal budget? Or are they, for most practical purposes, creatures of the federal government, whose income and outgo should all be included in the federal government's accounts?

In answering such questions, budget analysts normally consult two sources for guidance. One is the 1967 *Report of the President's Commission on Budget Concepts.* The other is budgetary precedent. Because of the unique features of the Administration's health proposal, however, neither source provides a definitive answer.

Considering the Administration's proposal in its entirety, CBO concludes that it would establish both a federal entitlement to health benefits and a system of mandatory payments to finance those benefits that represents an exercise of sovereign power. In administering the proposed program, regional alliances, corporate alliances, and state single-payer plans (if any) would operate primarily as agents of the federal government. Therefore, CBO believes that the financial transactions of the health alliances should be included in the federal government's accounts and the premium payments should be shown as governmental receipts rather than as offsets to spending. Nonetheless, because of the uniqueness and the vast size of the program, the budget document should distinguish the transactions of the alliances from other federal operations and show them separately, as is the practice for Social Security.

CONCLUSION

The Health Security Act is unique among proposals to restructure the health care system, both because of its scope and its attention to detail. Some critics of the proposal maintain that it is too complex. A major reason for its complexity, however, is that the proposal outlines in legislation the steps that would actually have to be taken to accomplish its goals. No other proposal has come close to attempting this. Other health care proposals might appear equally complex if they provided the same level of detail as the Administration on the implementation requirements.

Questions also arise about the capabilities of new and existing institutions to perform their assigned tasks under the proposal, the ambitious schedule for the development of the necessary infrastructure for the system, and the acceptability and sustainability of the proposed cost control mechanisms. These are very legitimate concerns but, again, they are not peculiar to the Health Security Act. Any proposal attempting to restructure the current health care system would face similar issues.

The ramifications of systemic changes to the health care system are quite uncertain; even the outcomes of incremental changes are difficult to predict. As the Congress considers the Administration's proposal and alternatives, both comprehensive and incremental, the inherent uncertainties of change must be weighed against the detrimental consequences of the current system—increasing numbers of people who lack the security of insurance coverage for health care and the rapidly rising costs of that care.

RESPONSES OF DR. REISCHAUER TO QUESTIONS SUBMITTED BY SENATOR ROTH

Question No. 1. **Corporate Alliances:** I have spent a lot of time talking to my people back home in Delaware about health care, and one of the things that the large employers tell me is that they *will not* opt into the corporate alliances—it just is not a realistic option for them. In addition, they would have to pay a 1% payroll tax for the privilege of using corporate alliances rather than regional alliances. I want to highlight the fact that the Joint Committee on Taxation (JCT) and CBO seem to agree with this analysis and strongly disagree with the Administration (*see* page 37 of CBO report), since JCT and CBO estimate a much smaller amount of revenue from the 1% payroll tax.

But, also, I want to say that *this fact will cause these employees to have less care and pay more money than the plan they are under now.* You see, the employees do not yet understand that because large employers back in Delaware can not opt to keep their generally "richer" current health plan, they will have to use the regional alliance, so the employees will generally get a benefit cut. Chances are also pretty good that these employees will have an increase in after tax cost. As I understand it, the companies tell me that they will use the federal dictated regional alliances, and pay out any savings from lower premiums in the form of higher cash wages. But this will mean more taxes for them to pay. In fact, your analysis seems to say that they will pay about $123 billion in higher taxes. This is in addition to the cut in benefits since they will lose their current, generally richer, health plan.

Please explain the difference between CBO and the Administration's analysis of this "corporate alliance" option for me. In addition, please explain how you arrived at your estimate of a revenue increase of $123 billion from increased payroll tax effects.

Answer. **Corporate Alliances.** In preparing its estimates, the Administration assumed that most eligible large firms would choose to establish corporate alliances. In contrast, CBO has projected that relatively few large firms would select this option. Based on data from the Bureau of the Census's Current Population Survey of March 1993, CBO estimates that the average firm would have to expect savings in premiums of about $800 per employee in 1996 to make it advantageous to establish a corporate alliance rather than enroll in a regional alliance. The firms meeting this condition employ an estimated 23 percent of the eligible employees in large firms. That percentage would decline in later years as corporate managers had a greater opportunity to observe regional alliances in operation and became more willing to make what would be an irrevocable decision to join a regional alliance. CBO estimates that after 2001, corporate alliances would cover 11 percent of the eligible employees in large firms.

Question No. 2. **Small Employers Will Pay Lower Wages:** When I speak to small employers in my state, they indicate that the new mandated premiums in the President's health plan will mean that they will not be able to pay as much in cash wages. In fact, some economists like Dr. Feldstein, have told me that if there is a health care mandate like the President's, then small employers that do not offer health care insurance will re-coup those costs by slowing any growth in wages. Since these new benefits will not be subject to tax, but cash wages are, it seems clear to me that this dynamic will result in lower tax collections for the federal government. Yet, your analysis shows an increase in taxes because of payroll effects of $123 billion. It seems to me that this large figure is both very speculative and optimistic. Some have said it looks like "smoke and mirrors." In fact, in the past when Republican President's proposed such "behavioral effects" in the budget, your office often disagreed and did not count any revenue increase as a result. In short, it appears that there is a double standard in your estimating process.

Please provide for me detailed analysis as to how you arrived at the $123 billion figure in your estimates as a result of "payroll tax effects." More specifically, I would like to know how much of a *decrease* in cash wages, if any, you built into your analysis as a result of small businesses transferring health insurance costs to their employees. How does that compare to any *increase* in wages paid by large employers who are saving on health premiums? Did you assume that all savings realized by businesses from health premiums are passed on to the employees in the form of higher wages, and if not, then how much is? Assuming, in general, that "small employers" are those that do not currently cover employees, then how many employees work for small employers; how many work for large employers; and can any analysis be offered as to how many will receive higher wages, and how many might be expected to receive lower wages because of the health mandate in the President's health plan?

What, if any, is the average reduction in wages to small business employees as a result of the President's proposed health care mandate? If there is not a reduction, then how do you explain Dr. Feldstein's statement to me that small employers will reduce wages in future years to pay for health care benefits? For large employers, what is the average increase in employee's wages as a result of premium savings? What is the average tax increase on employees of large companies as a result of the increase in cash wages that are substituting for premium costs? What is the average reduction, if any, in the *net* compensation package for employees of large businesses based on *after-tax wages and benefits,* and please provide an example as to the impact on employees of large businesses in Delaware earning $30,000; $40,000; $50,000; $60,000; $75,000 and $100,000 annually.

Answer. **Lower Wages.** The figure of $123 billion that you refer to is the total, over the 1996–2004 period, of the increase in revenues from both income and payroll taxes that we estimate the proposal would generate. In 2004, for example, CBO estimates that collections from personal income, payroll, and corporate taxes would rise by $34 billion. (CBO prepared these estimates in conjunction with the staff of the Joint Committee on Taxation.)

Corporate taxes would rise because under the proposal the government would assume some of the cost of providing health care for early retirees, thus removing that responsibility from employers and allowing profits to increase. But as you suggest, most of the increase in revenues would come from personal income and payroll taxes. CBO analysts calculated those figures by estimating the total bill for national health care and the proportion of it that would be covered by employers' contributions to premiums; they then compared the result with what they estimated all employers together would spend if the current health care system were to continue unchanged. Employers' lower spending for health care for both employees and retirees would amount to about $105 billion in 2004. Some of the reduced spending would be channeled into other nontaxable benefits, such as employers' contributions to

pensions, and some would go to increase profits. But the majority would be used to increase the cash income of workers. Applying the appropriate tax rates for corporate profits and personal income and payroll taxes, CBO computed an increase in federal revenues of about $34 billion in 1994.

The calculation required only one estimating convention and one behavioral assumption. The estimating convention—applied uniformly by long-established practice to all estimates of the effects on revenues of proposed legislation—is that nominal gross domestic product (GDP) and aggregate compensation to current employees would not change. The behavioral assumption describes how reducing employers' health care costs would affect other kinds of nontaxable benefits. (Similar behavioral assumptions are used, where appropriate, in all estimates of revenues.) In this case, CBO assumed that 15 percent of the reduction in health costs for current employees would be used to increase other benefits that escape taxation, and the remaining 85 percent would go into taxable wages. This assumption is based on results from recent empirical studies described in CBO's *Economic Implications of Rising Health Care Costs* (October 1992).

This calculation is an aggregate one and does not distinguish the extent of the possible rise in cash wages in many corporations that now offer health insurance or the extent of the drop that might occur in those that do not. CBO's analysis of the Administration's proposal recognizes and emphasizes that individual firms would face very different changes in their costs. However, we do not have enough information to track in detail what would happen to firms of different sizes. In general, most firms, even small ones, that currently offer insurance would eventually see reductions in their costs under the Administration's proposal because the proposal would cap the growth of premiums. If this aspect of the proposal were carried out as described, it would reduce costs even for firms that now offer significantly less generous benefits than the Administration's proposal would mandate. Moreover, the proposal offers subsidies to small, low-wage firms.

Similarly, CBO does not have sufficient information to estimate specific effects of the Administration's proposal on groups of employees, as you requested. Broadly speaking, most workers in firms that experienced a reduction in their costs for health insurance under the proposal would probably benefit: for those workers, after-tax cash wages would increase, and in addition some workers would receive better health benefits. Beyond that general result, outcomes for particular workers would depend on a wide variety of factors, including their current health care benefits and expenses, their family situation, whether or not they worked in firms that would gain from the cap on the percentage of payroll paid for insurance, and the competitive conditions that their employer faced in both hiring workers and selling products. CBO has no basis for estimating how these factors would play out among the states, among different-size firms, or among workers earning different wages.

AN ANALYSIS OF THE ADMINISTRATION'S HEALTH PROPOSAL

The Congress of the United States
Congressional Budget Office

Preface

The Congressional Budget Office (CBO) has prepared this analysis of the Administration's health proposal in response to several Congressional requests. The report contains an overview of the Administration's proposal and an estimate of its effects on national health expenditures and the federal budget. The report also examines the budgetary treatment of the proposal, its impact on the economy, and other considerations affecting the proposal's implementation.

More than 40 staff members in all of CBO's divisions contributed to the analysis contained in this report. Paul Van de Water coordinated the analysis of the Administration's proposal and the preparation of the report. Linda Bilheimer was responsible for Chapters 1 and 5, Paul Van de Water for Chapters 2 and 3, and Douglas Elmendorf and Douglas Hamilton for Chapter 4.

In the Budget Analysis Division, under the supervision of C.G. Nuckols, Paul Van de Water, Michael Miller, and Charles Seagrave, contributors were Paul Cullinan, Alan Fairbank, Scott Harrison, Jean Hearne, Lori Housman, Lisa Layman, Jeffrey Lemieux, Amy Plapp, Patrick Purcell, Kathleen Shepherd, and Connie Takata. In the Health and Human Resources Division, under the supervision of Nancy Gordon and Linda Bilheimer, contributors were B.K. Atrostic, Sandra Christensen, Carol Frost, Julia Jacobsen, Harriet Komisar, Susan Labovich, Carla Pedone, Murray Ross, Karen Smith, Ralph Smith, Cori Uccello, and Bruce Vavrichek. In the Macroeconomic Analysis Division, under the supervision of Robert Dennis and Douglas Hamilton, contributors were Douglas Elmendorf, Angelo Mascaro, Frank Russek, and Christopher Williams. Derek Briggs, Blake Mackey, and Michael Simpson provided able research assistance. Contributors in other divisions of CBO included Jan Acton, James Blum, Leonard Burman, Thomas Cuny, Ellen Davidson, Gail Del Balzo, Mark Desautels, Robert Hartman, Richard Kasten, Rosemary Marcuss, Marvin Phaup, and Robin Seiler.

CBO would also like to acknowledge the significant help provided by the staff of other federal agencies. The Bureau of the Census performed calculations according to CBO's specifications using data from County Business Patterns. The Health Care Financing Administration's Office of the Actuary provided other critical data and professional assistance. Staff from the Office of Management and Budget, the Domestic Policy Council, and the Department of Health and Human Services interpreted the Administration's proposal and explained the Administration's estimates.

Paul L. Houts supervised the editing and production of the report, assisted by Sherry Snyder. Major portions were edited by Paul L. Houts, Sherry Snyder, and Leah Mazade. Jeanne Burke, Sharon Corbin-Jallow, Dorothy Kornegay, Linda Lewis, and Ronald Moore assisted in the typing. Christian Spoor provided editorial assistance. With the assistance of Martina Wojak-Pistrow, Kathryn Quattrone prepared the study for final publication.

Robert D. Reischauer
Director

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Summary

The Health Security Act is a comprehensive proposal to provide a universal entitlement to health insurance for a broad range of services and to slow the growth of spending for health care. To achieve these goals, it would fundamentally restructure the current health care system, changing requirements and incentives for employers, consumers, insurers, and providers of care. Because of the magnitude of these changes, the full impact on the health care system is extremely difficult to predict.

The Administration's proposal would redesign the current system of financing for health care, while building on its existing employer base. All employers would be required to pay premiums on behalf of their employees, and all individuals and families--except Medicaid beneficiaries and others with very low income--would be required to pay at least part of their premiums. Subsidies would be available to help employers and low-income families meet these obligations and would also be available for retired people ages 55 to 64.

To strengthen the demand side of the health care marketplace, the proposal would establish regional purchasing alliances through which most people who worked for firms with 5,000 or fewer full-time employees would obtain health coverage, as would most other people under age 65 who had no connection to the labor force. Larger firms, firms participating in multiemployer group plans, rural electric cooperatives and telephone cooperative associations, as well as the U.S. Postal Service, would be entitled to establish their own corporate alliances. Medicare beneficiaries would generally remain outside the alliance system. States could choose to opt out of the regional alliance system entirely and establish a "single-payer" system of health care financing, in which the state would pay all providers directly.

Consumers would normally have access to a choice of health plans of different types--including at least one fee-for-service plan--that would be offered through the alliance in the area in which they lived. All plans would offer a standard package of benefits, which would be slightly more generous than the average plan currently offered by employers. To ensure that consumers could make informed choices about those plans, alliances would provide much more information about the plans they offered than is typically available today.

The primary objective of the proposal is to ensure that health coverage would be available at a reasonable price to everyone and that people could not be denied coverage because of their health status. Accordingly, strict requirements would be placed on the enrollment procedures that health plans could employ, requiring plans (within the limits imposed by their capacity and financial constraints) to accept all applicants, and prohibiting plans from excluding people because of preexisting medical conditions. A plan's premiums could not vary for any reason other than the type of family being insured, a requirement known as community rating. (Premiums for plans offered by corporate alliances could, in addition, vary among geographic areas.)

People entitled to Medicaid benefits because they also receive cash welfare payments would continue to obtain coverage from Medicaid but, like almost everyone else, would be enrolled in health plans offered through the regional alliances. Others who currently receive Medicaid benefits would lose that coverage, but most of them would be eligible for subsidies for their premiums.

The proposal would also expand several federal programs and institute new ones. Important among these provisions are coverage of prescription drugs for Medicare beneficiaries, the provision of "wrap-around" health care benefits for low-income children, and a new program to provide home- and community-based services for severely disabled people.

Financing for these initiatives and the subsidies that the federal government would pay to alliances would come from a variety of sources. They would include several new revenue measures, increases in income and payroll tax receipts generated by the change in the mix of employee compensation that would occur under the proposal, reductions in the Medicare and Medicaid programs, and assessments on premiums. States would also make maintenance-of-effort payments to alliances, reflecting their reduced obligations for Medicaid under the proposal.

To lower the rate of growth of health care spending, the proposal would establish a complex mechanism for limiting the growth of premiums for the standard benefit package--an approach that, if carried out as intended, would almost certainly be effective on that score. The proposal would also attempt to limit the obligations of the federal government for subsidy payments, but that endeavor would be less likely to succeed.

Uncertainty of the Estimates

Estimates of the interactive effects of so many complex changes to an industry that encompasses one-seventh of the economy are highly uncertain. Assumptions, used by the Congressional Budget Office (CBO) and other analysts, about people's behavioral responses to new incentives are frequently based on research evidence from small changes in the existing marketplace. In the case of the Administration's proposal, however, the entire marketplace and the configurations of the actors within it would be changing, and there is no precedent for estimating the effects on health spending or the economy.

Estimating the effects of any proposal to restructure the health care system is particularly difficult because, inevitably, the transition from the old to the new system would take several years. Focusing on the effects of proposals in their early years is, therefore, not very meaningful; it is the long-term impacts, when new coverages would be fully phased in and the system stabilized, that are important. Unfortunately, the uncertainty surrounding cost estimates increases significantly in the out years. Thus, although CBO believes that the most important estimates presented in this paper are those for 2004, they are also the most uncertain.

Financial Impact of the Proposal

National health expenditures would rise in the initial years of the Administration's proposal--an inevitable consequence of expanding health insurance coverage to the uninsured, increasing the generosity of the benefits that many insured people currently receive, and expanding home- and community-based services for the disabled. Over time, however, the combined effects of lowering the rate of growth of health insurance premiums and the cuts in the Medicare program would dominate. Thus, CBO projects that national health expenditures would fall $30 billion below the current CBO baseline by calendar year 2000, and would be $150 billion (7 percent) below that baseline in 2004.

The effects on the federal budget deficit show a similar pattern. The increase in the deficit is estimated to reach slightly more than $30 billion in 1998, the first year in which all states would be participating in the system, and then begin to fall. It would rise again in 2001 and 2002 because of two additional factors in those years: increases in the generosity of the standard benefit package that would occur in 2001, and the subsidies, beginning

in 2002, of state and local governments in their role as employers. By 2004, however, the estimated effects on the deficit are negligible, and CBO believes that the proposal holds the promise of reducing the deficit in the long term.

CBO's estimates of the effects of the proposal on the deficit differ only modestly from those of the Administration. Because the Administration developed estimates for the 1995-2000 period, comparisons for the out-years, which are more important, cannot be drawn. For the six-year period from 1995 through 2000, though, the Administration's estimates indicate that the proposal would reduce the deficit by about $60 billion. In contrast, CBO estimates that the deficit would increase by more than $70 billion over that period. The difference between these estimates is small, however, compared with the uncertainty surrounding the budget projections.

The primary difference between the two estimates stems from the amount of subsidies for employers, with CBO's estimate being considerably higher than the Administration's--by $25 billion in 2000, for example, or about half of the difference in the estimates of the effects on the deficit in that year. The estimates of subsidies for employers differ for three major reasons. CBO's estimates of premiums for the standard benefit package are higher than the Administration's, and estimates of these subsidies are extremely sensitive to the estimates of premiums. CBO also assumes that low-wage workers would cluster in firms that received subsidies, a factor not explicitly taken into account in the Administration's estimates of subsidies. Finally, CBO has used a different methodology than the Administration, one that captures more of the variation in average wages among firms.

Effects on the Economy

Although the Administration's proposal would make fundamental changes in the current health care system, the overall economic impact of those changes might not be large. Because the proposal would involve substantial redistributions within the economy, however, the impact on business costs and employment might be significant for individual firms and people. Similarly, though the proposal would have little predictable effect on national saving and investment, or on the balance of trade, some businesses could see their ability to compete with foreign firms either improving or worsening

The proposal would retain much of the current central role of employers in the health insurance system, requiring that a large part of health insurance premiums be paid in the first instance by employers. But businesses' costs for health care would be significantly reduced overall, both because the proposal would provide substantial subsidies to firms and because it would limit the growth of premiums. For example, the total premiums employers pay for active workers would drop by about $20 billion in the year 2000.

Although overall costs would go down, for some employers--particularly those that do not currently offer health insurance--costs would increase Changes in costs could also be pronounced among firms that currently offer insurance. They would rise for some businesses--especially those with young and relatively healthy work forces--as a result of the provisions for community rating. Conversely, businesses that now face high health care costs--because they are small and have little clout in the insurance market, have older or sicker work forces, or hold substantial responsibilities for retirees--would see lower costs.

Those employers facing an increase in their premiums would probably shift most of the added cost to their workers by reducing cash wages, much as occurs now in firms that offer health insurance Similarly, employees of firms that would pay less would receive higher wages.

For several reasons, the proposal would also affect people's decisions about whether they wanted to seek work or to stay home. For instance, the proposal would guarantee insurance for early retirees and directly subsidize the cost of that insurance. In other words, older people would no longer have to work simply because they needed access to affordable health insurance. A substantial number

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Conclusion

The Health Security Act is unique among proposals to restructure the health care system, both because of its scope and its attention to detail. Some critics of the proposal maintain that it is too complex. A major reason for its complexity, however, is that the proposal outlines in legislation the steps that would actually have to be taken to accomplish its goals. No other proposal has come close to attempting this. Other health care proposals might appear equally complex if they provided the same level of detail as the Administration on the implementation requirements.

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The ramifications of systemic changes to the health care system are quite uncertain, even the outcomes of incremental changes are difficult to predict. As the Congress considers the Administration's proposal and alternatives, both comprehensive and incremental, the inherent uncertainties of change must be weighed against the detrimental consequences of the current system--increasing numbers of people who lack the security of insurance coverage for health care and the rapidly rising costs of that care.

obligations. That package would cover the following:

- Hospital services;
- Services of health professionals;
- Emergency and ambulatory medical and surgical services;
- Clinical preventive services;
- Mental illness and substance abuse services;
- Family planning services and services for pregnant women;
- Hospice care;
- Home health care;
- Extended care;
- Ambulance services;
- Outpatient laboratory, radiology, and diagnostic services;
- Outpatient prescription drugs and biological products;
- Outpatient rehabilitation services;
- Durable medical equipment and prosthetic and orthotic devices;
- Vision care;
- Dental care;
- Health education classes; and
- Certain treatments under clinical investigation in approved research trials.

Coverage of some services would be phased in over time. Dental benefits, for example, would be very limited before 2001, and the coverage of mental illness and substance abuse services would also become more extensive in that year.

Although the proposed coverage of most services is comparable with that provided by relatively generous employment-based policies today, there are some differences. The coverage of preventive health services, for example, would be more extensive from the beginning than in most current health plans, as would the mental health and substance abuse benefits when they were fully phased in. By contrast, the prescription drug and hospital benefits in plans with higher cost sharing and (before 2001) the dental health benefits would be less generous than those that many employers currently provide.

Health Alliances

The Administration's proposal would expand the central role employers now play in purchasing health insurance and restructure the market for that insurance. All employers would have to pay part of the premiums for their employees' insurance. Moreover, the demand side of the health insurance market would be reorganized in order to engender greater market power for individuals and small firms, enable people to have a choice of health plans at a reasonable cost, and provide incentives for health plans to compete on the bases of both cost and quality.

To accomplish these goals, the proposal would establish a nationwide system of regional purchasing alliances. Most people who worked for firms with 5,000 or fewer full-time employees, as well as most people who were not in the labor force (including Medicaid beneficiaries), would be required to obtain health insurance coverage through those alliances. Medicare beneficiaries, however, would generally continue their coverage through that program.

Firms with more than 5,000 full-time employees, firms participating in large multiemployer group plans, rural electric cooperatives and telephone cooperative associations, and the U.S. Postal Service would be entitled to establish separate corporate purchasing alliances. Full-time employees of firms that did so would have to purchase their coverage through their firm's corporate alliance unless they had a spouse who worked for an employer that participated in a regional alliance. Such two-worker families could choose to obtain their insurance through either the corporate or the regional alliance.

Federal civilian employees would obtain their coverage through regional alliances starting in 1998, and the Office of Personnel Management (OPM) would make available to them one or more supplementary plans. OPM would also develop one or more plans that would supplement Medicare's benefits for retired federal workers and their dependents.

People who are now eligible for health coverage through certain federal agencies would still be able to receive their standard benefits through those agencies. Active-duty members of the armed forces would continue to receive their health benefits from the Department of Defense (DoD). Their dependents and military retirees could also obtain coverage through the DoD system if its resources permitted. Indians could obtain coverage through the Indian Health Service and veterans through the Department of Veterans Affairs system. Box 1-1 describes these aspects of the proposal.

Regional Alliances. These entities would be established by the states as either nonprofit organizations or state agencies. They would have nonoverlapping jurisdictions that could be a portion of a state or an entire state but could not cross state boundaries or

Box 1-1.
Health Plans Offered Through the Department of Defense, the Department of Veterans Affairs, and the Indian Health Service

In general, individuals who are currently eligible for health services from government agencies could receive their standard benefits through health plans offered by those agencies. Unlike the current situation, however, people selecting a government plan could not simultaneously participate in another plan covering the standard benefit package.

The Secretary of Defense would establish one or more Uniformed Services Health Plans that would cover at least all the items and services in the standard benefit package. Active-duty personnel would be required to enroll in those plans, for which they would pay minimal amounts. Other people eligible for military health care would have the choice of enrolling in a military plan if one was available, a plan offered by a regional or corporate alliance (for those under age 65), or Medicare (for those age 65 and over). Premium payments and other cost-sharing requirements for people who elected to enroll in military plans could not exceed the family share of premiums and cost-sharing amounts in health plans offered through regional alliances.

Military health plans would receive premium payments from Medicare on behalf of people enrolled in the Supplementary Medical Insurance program who selected a military plan. Conversely, the Department of Defense might make premium payments on behalf of people who were eligible for military plans but elected to participate in other plans.

In a similar manner, veterans could elect to enroll in health plans established by the Department of Veterans Affairs (VA). Those plans would be required to offer all the items and services in the standard benefit package, and they would also provide certain additional services specifically related to service-connected conditions. These additional services would be available to all veterans now eligible for them, regardless of whether they enrolled in a VA plan.

Low-income veterans and veterans with service-connected disabilities who enrolled in VA plans would not have to pay premiums or cost-sharing amounts, but most other veterans would pay amounts based on rules established by the regional alliance in the area in which the VA plan operated. VA health plans would be authorized, but not required, to enroll family members of VA enrollees subject to their paying the required premiums and cost-sharing amounts. Veterans who chose to enroll in other health plans would have no premiums paid on their behalf by the VA. VA plans would be eligible for reimbursement from Medicare, but only on behalf of participants who were eligible for Medicare, who also had no service-connected disabilities, and who were not defined by the VA as having low income.

The Indian Health Service (IHS) would also sponsor plans covering the standard benefit package for eligible Indians, who would not have to pay premiums or cost-sharing amounts. Family members who were not otherwise eligible could enroll in IHS plans but would be required to pay premiums and cost-sharing amounts. The IHS would make no payments for premiums or cost-sharing amounts for Indians who chose to enroll in non-IHS plans.

subdivide a metropolitan area within a state. Each regional alliance is supposed to ensure that its residents would have a choice of the health plans that contracted with the alliance, at least one of which would be a fee-for-service plan. The alliance would also be responsible for ensuring that residents had the necessary information with which to make informed choices and that they enrolled in a health plan.

In general, alliances would be required to contract with all health plans that met the state's standards and wished to offer insurance coverage in their area. Regional alliances could, however, refuse to contract with plans whose proposed premiums exceeded 120 percent of the target for the alliance's per capita premium or that had violated previous contracts with the alliance. The alliances would also collect funds from employers, households, and governments and make payments to the plans chosen by participants. Finally, they would have to meet federal requirements to keep their average premiums at or below specified targets.

Corporate Alliances. Corporate alliances would also have to offer participants a choice of plans, although that choice could be more restricted than in regional alliances. Specifically, corporate alliances would have to offer at least one traditional fee-for-service plan and at least two others of a different type, such as health maintenance organizations (HMOs). Like regional alliances, their responsibilities would include collecting and disseminating information about health plans and their outcomes, as well as meeting federally determined targets for cost containment.

Medicare and the Alliance System. The Medicare program would generally continue to function outside the system of regional and corporate alliances. Enrollment in plans offered through the alliances would be mandatory, however, for people eligible for Medicare if they or their spouse were employed at least 40 hours a month. In addition, some people could elect to stay in certain eligible plans when they became entitled to receive Medicare benefits. Finally, provided that they met certain requirements, states would also have the option to integrate all their Medicare beneficiaries into regional alliances.

Medicaid and the Alliance System. Medicaid beneficiaries who receive cash welfare payments would continue to be covered by Medicaid but would receive services in the standard benefit package through health plans offered by the regional alliances. These beneficiaries could choose any health plan that charged an average or below-average premium, would be absolved of other payments for premiums, and would have special limits on their cost-sharing liabilities. (They could choose a more expensive plan by paying the difference in premiums themselves.) For this group, the federal and state governments would also continue to make payments for benefits that Medicaid now covers but that would not be included in the standard benefit package.

In general, Medicaid beneficiaries who do not receive cash payments would no longer obtain coverage from Medicaid, except for long-term care and cost sharing required by Medicare. Instead, they would benefit both from the same subsidies available to other low-income people obtaining coverage through the alliance and from payments made by their employers if they were working. Almost all children eligible for Medicaid under current law would, however, continue to be covered for those services provided by Medicaid that would not be in the standard benefit package.

The Single-Payer Option for States. The Administration's proposal would allow states to opt out of the regional alliance system and establish a "single-payer" system of health care financing in which the state would pay all health care providers directly. States electing that option would assume responsibility for all people who would otherwise have been in regional alliances. They could also choose to enroll in their single-payer system all Medicare beneficiaries and people who would otherwise have been in corporate alliances.

Health Plans

The proposal envisions that people who obtained their health insurance through alliances would select from a variety of plans that contracted with their alliance, including fee-for-service plans, HMOs, and

point-of-service plans. Some people, however, might not be able to enroll in the plan of their choice—for example, if it was operating at capacity. Plans would have to comply with one of the three cost-sharing schedules that are specified in detail in the proposal—lower, higher, or combination cost sharing—as well as other requirements.

Requirements for Cost Sharing. Higher-cost-sharing plans would impose both specified deductible amounts and coinsurance (calculated as percentages of the providers' fees) according to a national schedule that is specified in the proposal. The use of flat copayments would be prohibited in those plans. Lower-cost-sharing plans would have no deductible amounts and no coinsurance (except for services obtained from providers outside the plan's network of providers). Such plans would charge flat copayment amounts for particular services according to a fixed national schedule also included in the proposal. Cost sharing in combination plans would basically follow the lower-cost-sharing model for in-network services and the higher-cost-sharing model for out-of-network services. In all three types of plans, maximum annual out-of-pocket payments would be the same: $1,500 for an individual and $3,000 for a family.

Requirements for Supplementary Coverage. The proposal would place strict requirements on supplementary health insurance. Insurers could not offer supplementary policies that would duplicate coverage offered in the standard benefit package. Any policies to cover services not included in the standard package would have to be available to all applicants, regardless of their state of residence, subject to capacity and financial constraints.[1]

All plans available through regional alliances would have to offer their enrollees supplementary coverage for cost-sharing amounts.[2] Lower- and combination-cost-sharing plans, however, would offer supplementary coverage only for deductible amounts and coinsurance required for services received from providers who did not have contracts with the plan. Only enrollees in a plan could purchase the supplementary coverage associated with that plan. Premiums for such coverage would have to be the same for all enrollees in a plan, and they would have to reflect the expected increase in use of services that would result from the reduced cost sharing. (Coverage of flat copayments, as opposed to coinsurance, would not be permitted.)

Certification Requirements for Health Plans. In order to contract with a regional alliance, health plans would have to be certified by the state in which the alliance was located. The criteria for certification would encompass standards for quality, financial stability, and capacity to deliver the standard benefit package, as well as requirements relating to community rating, enrollment, and coverage. Those for community rating would prohibit plans from varying premiums among residents of the alliance area (except for variations attributable to different types of families—individuals, couples, single-parent families, and two-parent families). The other requirements would prohibit medical underwriting and limitations on coverage so that no one would have coverage denied or restricted because of a preexisting condition. Those requirements would be stringent; a plan could not terminate or restrict coverage for any reason, even if enrollees did not pay their premiums.[3]

Corporate alliances could either contract with state-certified plans or offer self-insured plans that met the requirements of Title I of the Employee Retirement Income Security Act of 1974. Those plans would have to meet requirements for community rating, enrollment, and coverage just as plans offered by regional alliances would.

Requirements Relating to Essential Community Providers. All health plans would initially be required to enter into agreements to pay essential

1. Membership organizations and employers offering such policies could restrict them to their members and their own employees, respectively.

2. The proposal appears to prohibit corporate alliances from offering supplementary cost-sharing policies, but officials of the Administration have stated that they intended to place no constraints on corporate alliances. In fact, the proposal permits firms that formed corporate alliances to reimburse employees for those expenses.

3. Plans could, however, obtain approval to limit enrollment if they were operating at capacity or in order to maintain their financial stability.

community providers who wished to have such agreements. Essential community providers could either participate in the plan or receive payments from the plan without having a participating provider agreement. Certification as an essential community provider would be automatic for a wide range of private nonprofit and public providers that receive funding under the Public Health Service or Social Security Act.[4] Certified providers would also include Indian health programs and providers of school health services that would receive funding under the proposal, as well as other providers and organizations certified by the Secretary of Health and Human Services (HHS).

The requirement for health plans to contract with essential community providers would end five years after an alliance first offered a health plan. No later than March 2001, however, the Secretary of HHS would recommend to the Congress whether to continue, modify, or terminate the requirement.

Requirements Relating to Workers' Compensation and Automobile Insurance. All health plans that provided services to enrollees through participating providers would be required to provide or arrange for workers' compensation services for their enrollees. Workers' compensation carriers would reimburse health plans for those services. Workers' compensation services could, however, be provided through alternative means if the carrier and the injured worker agreed.

Similarly, enrollees would generally receive from their health plans any medical benefits to which they were entitled through their automobile insurance. Health plans would be required to arrange for referral services, as necessary, to ensure the appropriate treatment for injured individuals. Automobile insurance carriers would reimburse health plans for those services. As with workers' compensation insurance, injured individuals and carriers could agree to alternative arrangements.

4 Those providers would include community and migrant health centers, providers of health services for the homeless and people in public housing, family planning clinics, providers who treat people with AIDS (acquired immune deficiency syndrome) and are funded under the Ryan White Act, maternal and child health providers, and federally qualified health centers and rural health clinics.

Federal Program Initiatives and Expansions

In addition to the new program to provide universal health insurance coverage, the Administration's proposal would create several federal programs and would expand others. Changes in tax policy (discussed in a later section) would also benefit some people, such as those with large expenses for long-term care.

Medicare's Coverage of Prescription Drugs

Starting in January 1996, Medicare's Supplementary Medical Insurance (SMI) benefit package would cover prescription drugs for outpatients. This new benefit would have a $250 deductible amount, 20 percent coinsurance, and an out-of-pocket limit of $1,000. The deductible and out-of-pocket limit would be adjusted each year to ensure that neither the percentage of individuals satisfying the deductible nor the average percentage of enrollees receiving benefits would change.

Several new program requirements would attempt to restrain potential expenditures for prescription drugs. Medicare would limit reimbursement to pharmacists, generally paying them the lesser of the 90th percentile of pharmacies' charges for a particular drug or their acquisition cost plus a dispensing fee. In addition, drug manufacturers would have to provide rebates to Medicare for all nongeneric drugs sold to enrollees.

Home- and Community-Based Services for Severely Disabled People

The Administration's proposal would establish a new grant program for the states to provide home- and community-based services for people with severe disabilities. Although all people who met the disability criteria would be eligible to receive services from this program, it would not be an entitlement for disabled individuals; the number actually receiving services would depend on the amount of

funding appropriated. Federal contributions to the program, which would be phased in over seven years, would be capped, and states would be required to provide some funding.

The total federal budget for the program would be $4.5 billion in fiscal year 1996, rising to $38.3 billion in 2003. Increases in subsequent years would reflect changes in the consumer price index (CPI) and the size of the disabled population. As in Medicaid, a state's share of the funding would vary according to its per capita income, but the share would be much lower than in the Medicaid program, ranging from 5 percent to 22 percent of expenditures for services. If states transferred severely disabled people from the Medicaid program to the new program, thereby reducing federal expenditures for home- and community-based services under Medicaid, the federal budget caps for the new program would increase accordingly.

States would have to impose cost-sharing requirements on all program participants on a sliding scale according to income. Participants with family income below 150 percent of the poverty level would pay nothing; those with family income at or above 250 percent of the poverty level would pay the maximum cost-sharing rate of 25 percent.

Expansions in Medicaid's Coverage of Long-Term Care

Three features of Medicaid's coverage of long-term care would change under the Administration's proposal, two of which would expand eligibility for nursing home services. At their option, states could raise the amount of assets that may be excluded when determining the eligibility of single individuals for nursing home services (the asset disregard) from the current limit of $2,000 to as high as $12,000. In addition, all states would be required to grant eligibility for nursing home services to people who would meet the income and asset requirements for eligibility if their nursing home expenses were deducted from their income. (States currently have the option to grant eligibility to this group of people, but about one-third of the states do not do so.)

A third provision would require all states to allow nursing home residents who are Medicaid beneficiaries to keep at least $50 a month for their personal needs. Because almost half the states now set this allowance at the minimum allowed ($30), some beneficiaries would contribute less to the cost of their care. The federal government would pay for the resulting increase in Medicaid spending.

"Wraparound" Benefits for Low-Income Children

Because the current Medicaid program provides a wider range of services than those included in the standard benefit package, so-called wraparound benefits (apart from long-term care) would be provided to children now eligible for Medicaid. Although these benefits would be financed entirely by the federal government, states' maintenance-of-effort payments would, in effect, pay for roughly their traditional share of costs for these additional services for children in families receiving cash welfare benefits. Thus, the federal government would, in effect, take over the financing of these additional services only for children in families who did not receive cash benefits.

Expenditures for these benefits would be limited, however, based on the combined fiscal year 1993 federal and state spending for them. This limit would be updated to account for changes in the number of eligible children and adjusted by Medicaid-specific inflation factors through 1998 and by the "general health care inflation factor" combined with the rate of growth in the population under age 65 thereafter.[5]

5. For the 1996-2000 period, the "general health care inflation factor" would be the increase in the CPI plus specific amounts—1.5 percentage points in 1996, 1 percentage point in 1997, 0.5 percentage point in 1998, and zero in 1999 and 2000. After 2000, if the Congress did not act, the default factor would be the percentage increase in the CPI combined with the percentage growth in real gross domestic product per capita. (An actuarial adjustment would also be made in 2001.)

Funding for Graduate Medical Education and Payments to Academic Health Centers

The Administration's proposal would restructure the current system of federal subsidies for graduate medical education and academic health centers (and teaching hospitals) to account for the special costs they incur. It would emphasize the training of primary care physicians; both the alliances and Medicare would help to pay for the training of physicians. The proposal would also authorize $200 million a year for graduate nursing education and $400 million a year for Public Health Service programs for the training of minorities and of health professionals specializing in primary care.

A new National Council on Graduate Medical Education would authorize the number of residency positions, by specialty, in graduate medical education programs that received federal funding. At least 55 percent of residents who completed eligible residency programs would have to be in primary care--that is, in family medicine, general internal medicine, general pediatrics, or obstetrics and gynecology. That requirement would first hold for residents entering training in the 1998-1999 academic year.

Funding for the direct costs of approved training programs for physicians would be $3.2 billion in calendar year 1996, rising to $5.8 billion in both 1999 and 2000. In subsequent years, the amount would be the previous year's level increased by the general health care inflation factor. Under the Administration's proposal, Medicare would contribute $1.5 billion in fiscal year 1996, $1.6 billion in 1997 and 1998, and the 1998 level increased by the CPI in subsequent years. Thus, Medicare's relative contribution would probably decline after 2000 since total payments would almost certainly be rising faster than Medicare's contribution.

Medicare's relative contribution to payments to academic health centers (and teaching hospitals) for the indirect costs of graduate medical education would also probably decline over time. Such payments would total $3.1 billion in calendar year 1996, rise to $3.8 billion in 2000, and then increase in subsequent years by the general health care inflation factor. Of these amounts, Medicare would pay $2.1 billion in fiscal year 1996, $2.0 billion in 1997 and 1998, and that amount inflated by the CPI in subsequent years. The remaining funding for both the direct and indirect costs of graduate medical education would come as needed from a 1.5 percent assessment on total premiums paid to regional and multiemployer corporate alliances and from part of the 1 percent tax on the total payrolls of all other employers who established corporate alliances.

Expansion of the WIC Program

The proposal would establish a special Treasury fund subject to discretionary appropriations that, in addition to the regular appropriations for the Special Supplemental Food Program for Women, Infants, and Children (WIC), would help bring the program up to full funding by the end of fiscal year 1996 and then maintain full funding levels. To that end, the Secretary of the Treasury would credit annual amounts to the fund totaling $1.85 billion over the 1996-2000 period. These annual amounts would be available for spending, however, only if the regular appropriation for the year provided new budgetary authority for WIC at levels specified in the proposal.

Public Health Service Initiatives

Activities of the Public Health Service would expand significantly in a number of areas ranging from biomedical and behavioral research to health services for medically underserved populations. To accomplish that expansion, funding for a Public Health Service Initiative would be authorized.

Financing Provisions

Premiums paid by employers and households and payments by the federal and state governments would finance the insurance coverage obtained through the alliances. Employers would pay premi-

ums for all employees who worked at least 40 hours a month.[6] Except for Medicaid beneficiaries who receive cash assistance, nonelderly individuals and families would, in general, be responsible for paying the part of the premium that was not contributed by employers. Families with no workers, or with self-employed workers only, would be responsible for the entire premium for the plans they selected.

Government subsidies would be available, however, for low-income people and for people between the ages of 55 and 64 who had retired from the labor force. Employers, except for those that formed corporate alliances, would be entitled to subsidies that ensured that their payments for health insurance premiums did not exceed certain fractions of their payroll.

The costs of financing the subsidies, expanding the Medicare program, and augmenting various mandatory and discretionary federal health programs would be covered by states' maintenance-of-effort payments, higher SMI premiums, an increase in the excise tax on tobacco, an assessment on the payroll of firms that established corporate alliances, and other assessments and tax changes, as well as by various reductions in the Medicare and Medicaid programs.

Premiums Paid to Alliances

The premiums charged by any health plan offered through a regional alliance for the standard benefit package could vary only by the type of family (individual, couple, one-parent family, and two-parent family); they could not vary by age, sex, or health status. Premiums for plans offered by a corporate alliance, however, could also vary by geographic area. Moreover, the relationship among premiums for different types of families would be fixed and uniform across all regional alliances. For example, the premium for a couple would have to be twice that for an individual in the same plan.[7]

The distribution of premium payments among families and employers would be based on the premise that employers should pay about 80 percent of the premium for full-time workers, and families the remaining 20 percent. The actual proportions would vary, however, for several reasons.

Every family who enrolled in a plan offered by a regional alliance would be assigned an "alliance credit amount" that would equal 80 percent of the weighted average premium in the alliance for that type of family. The weighted average premium for a specific family type would be calculated by averaging premiums for that family type for all the plans in the alliance, weighting the premiums by the number of families of that type in each plan. The family's portion of the premium would be the difference between the premium for the plan selected by the family and the alliance credit amount, subject to various other adjustments, including subsidies.

In contrast, an employer's payment would not equal the alliance credit amount because families contain, on average, more than one worker for whom some employer would be paying premiums. An employer's payments would also not be determined by the premiums of the particular plans selected by its employees. Rather, for full-time workers in a specific family type, each employer's payments would take into account the number of workers of that family type in the alliance—for example, the more two-parent families there were with two full-time workers, the smaller the proportion of the 80 percent employer share any particular employer would have to pay.[8]

More specifically, setting aside the possibility of other adjustments (such as the subsidies for firms that are described below), an employer's payments would be calculated as follows:

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6. Two exceptions are children under age 18 and full-time students under age 24 who are dependent on their parents; they would be covered by their parents' policies even if they were employed.

7. Each corporate alliance would have some discretion, but all plans it offered within the same geographic area would have to have the same relationship among premiums for different types of families.

8. In calculating these payments, families with members eligible for Aid to Families with Dependent Children, Supplemental Security Income, or Medicare would be excluded. In addition, an employer's payments would be scaled proportionately for part-time workers, defined to be those who work between 10 and 30 hours per week.

- For individuals, the amount paid by each employer would be 80 percent of the weighted average premium for single individuals in the alliance.

- For couples, the amount would be 80 percent of the total premium payments for couples (that is, the number of couples in the alliance multiplied by the alliance's weighted average premium for couples) divided by the number of couples plus the number of "extra workers." Extra workers are the full-time-equivalent workers in couples with more than one working member. This complicated formulation means that the amount an employer would pay per worker would be reduced as the number of workers in the alliance who were part of a couple rose relative to the number of couples. The reductions in an employer's payments from this adjustment, which derives primarily from the presence of two-worker couples, would be spread among couples without a worker or with only one part-time or full-time worker.

- For both single- and two-parent families, an employer's payments would equal 80 percent of the combined total premium payments for both family types divided by the sum of the number of single-parent families, the number of two-parent families, and the number of extra workers in two-parent families. The aggregation of single- and two-parent families would ensure that an employer paid the same amount for employees in families with children, regardless of the number of parents in the family.

Unlike employers in regional alliances, those that formed corporate alliances would pay an amount similar to the alliance credit amount--namely, 80 percent of the weighted average premium in the corporate alliance for employees in each type of family. (Because the corporate alliance would receive payments for spouses eligible to enroll in other alliances, however, the cost per worker would be reduced in much the same way as for an employer in a regional alliance.) An exception would apply to full-time workers with average annual earnings of less than $15,000 (indexed by the CPI after 1994). For these workers, the employer would have to pay the greater of 80 percent of the weighted average premium or 95 percent of the premium of the lowest-cost plan offered by the corporate alliance that had either lower or combination cost sharing.

Employers in either regional or corporate alliances could pay more than the required minimum amounts on behalf of their employees, but their additional payments for the standard benefit package could not exceed the amount of the family share for the highest-cost plan in the alliance. If an employer chose to pay more, the amounts its employees owed would be reduced correspondingly. Such voluntary payments would have to be equal for all employees in the same type of family, however, regardless of the plans that were selected. Moreover, if the employer's payments totaled more than the premium of the plan selected by the employee, the difference would be returned to the employee (and included in taxable income).

Individuals and families would be responsible for the family share of the premium--that is, the difference between the premium charged by the plan they selected and the alliance credit amount--unless their employers paid more than the required minimum. For most individuals and families, their obligation would average about 20 percent of the total premium costs, but it could be more or less depending on whether they selected a plan with an above- or below-average cost.

Individuals and families with no worker or only a part-time worker would be responsible for some or all of the employer portion, as well as the family portion, of their premiums.[9] The self-employed would pay 7.9 percent of their self-employment income or the employer portion, whichever was lower, even if their family had another full-time worker. (The required percentage would be lower if they were eligible for the subsidies provided to low-wage firms that are discussed below.)

If some employers and families did not pay the premiums they owed to regional alliances, other

9. A family would not be responsible for the employer share if one of its members was employed full time for that month or if two members worked part time and their combined hours of employment totaled at least 120 that month.

employers and families in those alliances would bear the consequences. Each year, an alliance would estimate the amount of premiums that it would be unlikely to collect, adjusted for over- or underestimates in the previous year. It would then adjust the premiums for each type of family by the same proportion in order to collect the desired total from those expected to pay the amounts they owed.

Subsidies

The obligation to pay premiums that the Administration's proposal would place on employers and families would be reduced by a variety of subsidies designed to assist low-income families and employers. These subsidies would be available only for families that obtained, and employers that paid for, coverage through regional alliances. In other words, employers that established corporate alliances would not be eligible for subsidies and would have to keep the amounts paid by their low-income employees below certain limits.

Subsidies for Families. Families receiving benefits from Aid to Families with Dependent Children (AFDC) or Supplemental Security Income (SSI) and people whose income was below a very low threshold ($1,000 in 1994, inflated by the CPI thereafter) would not have to pay the family portion of the premium for plans with premiums at or below the weighted average for that type of family. The family's maximum obligation would rise with income so that at 150 percent of the poverty level a family would pay the lesser of 20 percent of the weighted average premium or 3.9 percent of income. Payments for the family portion would be limited to 3.9 percent of income for all families with income below $40,000 (in 1994, inflated by the CPI thereafter). If no plan with a premium at or below the weighted average was available (for example, because all such plans were at capacity), the family's obligation would stay the same and the amount of the government subsidy would increase.

Subsidies would also be available for individuals and families who were responsible for paying part or all of the employer share of their premiums and for the self-employed who worked part-time and whose remaining obligation for the employer share was not met by the work of other family members. The subsidies would be set on a sliding scale and would be phased out when nonwage income--which includes items such as rents, interest, and dividends--reached 250 percent of the poverty level.

Families in regional alliance plans who had income below 150 percent of the poverty level would also be eligible for reductions in cost sharing if they lived in areas in which no lower- or combination-cost-sharing plan was available at a cost that did not exceed the weighted average premium for their type of family. Families meeting those criteria would be obligated only for the cost-sharing amounts they would have paid if they were enrolled in lower-cost-sharing plans. Regional alliances would pay the remainder to the plans. Special subsidies for cost sharing would also apply to Medicaid beneficiaries, who would pay only 20 percent of the copayment amounts required by lower- or combination-cost-sharing plans. The plans themselves would generally finance the cost-sharing subsidies for Medicaid beneficiaries.

Early retirees who would be eligible for Medicare's Hospital Insurance (HI) benefits when they turned 65 would receive special subsidies for their premiums. (Early retirees would be people between the ages of 55 and 64 who were not employed full time.) Spouses under age 65 who were not employed and other dependents of early retirees would also be subsidized. Retirees in these families would be entitled to government subsidies covering the employer share, leaving them to pay only the difference between the premium for the plans they chose and the alliance credit amount. The subsidies would be reduced by employers' payments for retirees or their spouses who worked part time. If the spouse of a retiree worked full time, no government subsidy would be necessary.

Subsidies for Firms. The Administration's proposal would also place limits on the premiums paid by employers in regional alliances. With the exception of the federal, state, and local governments, which would not be entitled to caps on their premium payments for employees until 2002, an employer's premium payments to regional alliance

plans would generally not exceed 7.9 percent of payroll.[10]

Small, low-wage employers would have lower caps, which would vary according to both the size of the firm and its wage level. The lowest proportion of payroll (3.5 percent) would be paid by firms with fewer than 25 full-time-equivalent employees and average annual wages per full-time-equivalent employee of not more than $12,000. The employers' obligation would increase to reach 7.9 percent for firms with 75 or more employees or average wages of more than $24,000. The proportion of small employers that would be eligible for these additional subsidies would fall over time because the wage thresholds on which the subsidies are based would not be indexed.

Changes in the Internal Revenue Code

Receipts from a variety of sources would finance the Administration's proposal, although some new tax incentives would reduce revenues. Detailed information on the amendments to the Internal Revenue Code contained in the Administration's proposal is available in a recent publication from the Joint Committee on Taxation.[11] Therefore, only a summary of those provisions is provided here.

One provision would increase the excise tax on cigarettes by 75 cents per pack and the taxes on other tobacco products by approximately the same amount per pound of tobacco content. In addition, employers that no longer had to pay for their retirees' health coverage would have to pay a temporary assessment. Employers that established corporate alliances would be required to pay a 1 percent payroll tax, in part to help pay for the federal grants for graduate medical education, nursing education, and academic health centers. Multiemployer corporate alliances and regional alliances would have to pay a 1.5 percent assessment on premiums for the same purposes.

Other provisions would broaden the definition of the tax base for self-employed people. First, more business income of shareholders in S corporations would be treated as "wages" for the purpose of calculating the corporation's eligibility for subsidies of its premiums. Specifically, individuals who owned more than 2 percent of the stock in an S corporation and who participated materially in the business would have their distributive share of the corporation's income from the service-related business treated as wages for this purpose. Likewise, more business income of limited partners in partnerships would be treated as wages for the same purpose. The added income of S corporation shareholders and limited partners would also become subject to employment taxes. These changes would not only reduce subsidies for employers but would also increase payroll tax receipts (as well as future benefits from Social Security and unemployment insurance).

The proposal would also require all state and local employees to pay Medicare's HI payroll tax. Currently, workers hired before April 1, 1986, in states that do not have a voluntary participation agreement with the federal government do not pay this tax, although many are eligible for Medicare's benefits through their spouse or nongovernmental employment. The increase in Medicare's revenue from this proposal would be partially offset by higher future spending because more people would participate in the program.

Two other provisions would reduce subsidies received by high-income retirees. Medicare enrollees with modified adjusted gross income above a specified threshold amount ($90,000 for single taxpayers and $115,000 for married taxpayers filing a joint return) would, in effect, have to pay higher premiums for Supplementary Medical Insurance. The maximum SMI premium for high-income Medicare beneficiaries would cover about 75 percent of the average benefits per enrollee, up from the current level of about 25 percent. In addition, high-income early retirees who would otherwise be eligible to receive subsidies for the employer share of

10. Employers eligible to establish corporate alliances that chose to participate in a regional alliance would not be eligible for these subsidies for the first four years. The subsidies would, however, be phased in during the next four years.

11. Joint Committee on Taxation, *Description and Analysis of Title VII of H.R. 3600, S. 1757, and S. 1775 ("Health Security Act")*, JCS-20-93 (December 20, 1993).

their health insurance premiums would be required to pay that share themselves.

The Administration's proposal would leave the tax treatment of employers' payments for health benefits largely untouched until 2004. As under current law, the proposal would allow the exclusion from employees' incomes of employers' payments for the standard benefit package and for cost-sharing amounts under the standard package, including premiums for cost-sharing supplements. But the proposal would expand the exclusion for employers' payments for qualified long-term care insurance.

Beginning in 2004, employer-paid premiums for supplementary coverage of additional services would no longer be excludable from employees' income for income tax and payroll tax purposes. In keeping with that provision, beginning in 1997, coverage provided through flexible spending accounts would be tax-exempt only for benefits related to the standard package. Also beginning in that year, employers generally could not include health benefits in "cafeteria" plans.

If employers chose to pay more of their employees' premiums than the minimum required, they would have to make equal voluntary payments for all employees in the same type of family. Thus, the employer's total payment could exceed the total premium of the plan selected by an employee. In such a case, the employee would be entitled to a cash rebate that would be subject to both income and payroll taxes.

The proposal also would expand the income tax subsidy for health insurance purchased by the self-employed; it would do so by making permanent and later increasing a tax deduction for health insurance premiums. The proposal would reinstate the 25 percent deduction that expired at the end of 1993 and increase it to 100 percent of premiums for the standard benefit package beginning in 1997 (or 1996 if the state had begun participating in the new system).

By contrast, the proposal would put tighter limits on deductions for taxpayers who prepaid their health insurance premiums. If taxpayers made those premium payments or other payments for medical care, the benefits from which would extend for more than a year after the payment, that amount would be treated as having been paid on a pro rata basis over the period in which the benefits were received. That provision would preclude taxpayers from claiming a large tax deduction for a lump-sum payment for future health benefits.

Three tax provisions related to long-term care would lower revenue. One such provision would provide tax relief for individuals with high expenses for long-term care, and another would offer a tax subsidy to encourage people to purchase private insurance for long-term care. Taxpayers could claim an itemized deduction for spending on qualified long-term care services provided to themselves, their spouses, or dependents for which they had not been reimbursed, if those expenses plus their other qualified medical expenses exceeded 7.5 percent of their adjusted gross income. Premiums for qualified long-term care policies would also count as qualified medical expenses for purposes of itemized deductions. And as mentioned above, the exclusion of an employer's payment of premiums for qualified long-term care policies from an employee's income would be expanded; benefits received from such policies would also be excluded from income.

Other tax provisions in the Administration's proposal include changing the tax treatment of accelerated death benefits under life insurance contracts, providing tax incentives to encourage primary care physicians to practice in areas designated as having a shortage of health professionals, and giving tax credits for personal assistance services for disabled workers.

Reductions in the Medicare Program

A major part of the funding for the proposal would come from reductions in the Medicare program. Some of them would affect the Hospital Insurance program, some would affect the Supplementary Medical Insurance program, and some would affect both. (Increases in SMI premiums for high-income enrollees were discussed above because they would be collected through the income tax system.)

Spending for the HI program would be reduced primarily because payment rates to providers would be lower than under current law. Specific provisions of the proposal would:

- Reduce the updates to the per-case rates used by Medicare's prospective payment system (PPS), which pays for inpatient hospital services, for fiscal years 1997 through 2000;
- Eliminate the adjustment to PPS payments for the indirect costs of patient care that are related to hospitals' medical education programs--although a portion of the amount that would have been paid under this adjustment would be transferred to the fund for academic health centers;
- Reduce the base payment rates for capital-related costs of inpatient hospital services and reduce the updates applied to those payment rates for fiscal years 1996 through 2003;
- In states that were participating in the proposed new health care system, revise and, on average, reduce the PPS payment adjustment for hospitals that treat a disproportionately large share of low-income patients; and
- Reduce the updates to some payment rates for skilled nursing facilities in fiscal year 1996.

The largest reductions in spending for the SMI program compared with current law would result from lower payments for physicians. The specific provisions would:

- Establish goals for cumulative expenditures for physicians' services. Currently, the target rate of growth for each year is based on the prior year's actual rate of growth in outlays for physicians' services, without regard to the prior year's target rate of growth. Under this proposal, the growth target for outlays for physicians' services would be built on a designated base-year target (fiscal year 1994) and updated annually for changes in enrollment and inflation but not for actual growth in outlays above or below the targets for prior years.
- Institute a new system for setting the target rate of growth for payments to physicians. The new system would both substitute the average rate of growth in real gross domestic product (GDP) per capita (plus 1.5 percentage points for primary care services only) for a measure of the change in the volume and intensity of services provided by physicians during the previous five years, and eliminate the annual percentage reduction known as the performance standard factor.
- Eliminate the floor on the reduction permitted in the default update for physicians' payment rates. Currently, there is no upper limit on increases in physicians' fees under the default update formula, but fees cannot decrease by more than 5 percentage points.
- Reduce the conversion factor for the fee schedule for services (except for primary care) provided by physicians by 3 percent in 1995. The conversion factor is a dollar amount that converts the fee schedule's relative value units into payment amounts.
- Limit payments for physicians' services provided by medical staffs at high-cost hospitals, effective January 1, 1998. This proposal would establish limits on Medicare's payments for physicians' services per inpatient hospital admission, similar to limits on payments for hospital services.
- Limit total payments for certain outpatient hospital services to Medicare's approved amounts, effective July 1, 1994. Medicare enrollees' coinsurance liabilities for hospitals' outpatient services are now based on the hospitals' actual charges rather than on Medicare's (typically lower) approved amount for the services. Because Medicare usually pays 80 percent of the approved amount, hospitals often receive more than the total approved amount. This provision would reduce Medicare's payments for hospitals' outpatient services by the amount of patients' extra payments for coinsurance.

- Require Medicare beneficiaries to pay 20 percent coinsurance for all laboratory services, effective January 1, 1995. Medicare currently does not require copayments for clinical laboratory services, although most other SMI services are subject to a 20 percent coinsurance requirement.

- Establish a competitive acquisition process for magnetic resonance imaging tests, computerized axial tomography scans, oxygen and oxygen equipment, laboratory services, and other items at the discretion of the Secretary of HHS, effective January 1, 1995. If competitive bidding did not reduce average prices for those services by at least 10 percent, the Secretary would reduce Medicare's approved fees for those services to accomplish the same goal.

The provisions that would affect both Hospital Insurance and Supplementary Medical Insurance are quite diverse. They would:

- Retain Medicare's role as a secondary payer for disabled employees and employees with end-stage renal disease (who would be insured through their firms). Under current law, Medicare would become the primary payer for those enrollees as of 1999.

- Establish new standards for Medicare's payments to HMOs and competitive medical plans with risk-sharing contracts. Currently, Medicare pays 95 percent of the average adjusted per capita cost (AAPCC) for Medicare enrollees in each county. The program would establish a range around the HI and SMI components of the AAPCC, varying from 80 percent of the national average value up to 150 percent for SMI services and 170 percent for HI services. The intent would be to encourage more HMOs to participate in Medicare while establishing reasonable limits on reimbursement in counties whose AAPCC is high.

- Reduce the limits on payments for routine costs for home health services. In past years, Medicare's payments for home health services were limited to no more than 112 percent of average home health costs nationwide. This provision would reduce the limit to 100 percent of median costs nationwide.

- Require beneficiaries to make a copayment of 10 percent of the average costs for home health visits, excluding visits that occurred within 30 days of discharge from a hospital. Currently, Medicare requires no copayment for home health visits.

- Require the Secretary of HHS to contract with "centers of excellence" for the provision of cataract and coronary by-pass surgery and other services to Medicare beneficiaries, thereby expanding current demonstration projects to all urban areas. Medicare would contract with individual centers using a flat payment rate for all services associated with the affected surgical procedures. Patients would be encouraged to use the centers through rebates equal to 10 percent of the government's savings from the centers.

Reductions in the Medicaid Program

The cost of the Medicaid program would be substantially less than under current law. The proposal would terminate coverage for adult beneficiaries who did not also receive cash welfare benefits and would limit the rate of growth of the per capita payments to regional alliances for beneficiaries who did receive cash benefits, as discussed above. In addition, the proposal would end Medicaid's payments to disproportionate share hospitals--those that treat a relatively high proportion of low-income and uninsured patients--when the state began participating in the new system.

Issues of Governance

The Administration's proposal would place new responsibilities on the federal and state governments, create a variety of new institutions, and specify a complex flow of resources among those institutions.

The Role of the Federal Government

The federal government would play the major role in designing and financing the proposed health care system. Many of its functions would be the responsibility of a newly created National Health Board; other important responsibilities would fall to the Department of Health and Human Services and the Department of Labor.

Functions of the National Health Board. The National Health Board would have the mandate to:

- Interpret the standard benefit package;
- Oversee the cost containment provisions for regional alliances and certify that those requirements were met;
- Develop and implement eligibility rules relating to the coverage of certain individuals and families;
- Develop and implement standards for a national health information system for measuring the quality of health care;
- Establish and assume responsibility for a system to manage and improve the quality of care;
- Develop the multiplicative factors for converting premium amounts for individuals into premiums for couples, single-parent families, and two-parent families;
- Develop methods for adjusting premium payments to health plans so that the premiums reflected the health risks of their enrollees;
- Facilitate the development of a system of reinsurance so that plans could protect themselves against the financial consequences of enrolling a disproportionately large number of people with expensive medical conditions;
- Develop capital standards for health plans that contract with regional alliances;
- Develop standards for state guaranty funds, which would be used to pay providers in the event that a health plan offered by a regional alliance failed;
- Establish criteria that states must meet to begin participating in the system and monitor their compliance; and
- Review documents submitted by the states describing their proposed health care systems and approve or disapprove them.

Federal Initiatives to Ensure Compliance by States. The federal government would not only establish most of the criteria that states and alliances would have to meet but would also have to ensure that states met those standards. To that end, federal planning grants would be available to assist states in setting up their health care systems. The National Health Board, moreover, would have considerable authority to impose sanctions if necessary to enforce the standards. If it determined that a state's noncompliance resulted from the actions of a particular regional alliance, the board could order that alliance to comply and take additional measures to assure that it did so. The board could also require the Secretary of Health and Human Services to reduce federal payments to states for items such as academic health centers and health services research as a sanction for noncompliance. If, however, the board determined that a state was sufficiently far out of compliance that people's access to health services would be seriously jeopardized, the Department of Health and Human Services would take over the operation of that state's system. (The federal government would impose a 15 percent surcharge on total premiums in those circumstances.)

Oversight of Regional and Corporate Alliances. The Department of Health and Human Services would oversee the financial management of the regional alliances. Accordingly, the department would develop standards and conduct periodic audits relating to the alliances' enrollment of eligible individuals, their management of subsidies for premiums and cost-sharing amounts, and their overall financial management.

The Department of Labor would assume major responsibility for oversight of corporate alliances and employers in regional alliances. In particular, it

would ensure that employers in regional alliances paid their share of premiums, withheld and paid their employees' family share of premiums, and submitted timely reports. The department would also temporarily take over any insolvent self-insured corporate alliances; for that purpose, it would establish an insolvency fund to which self-insured corporate alliances would be required to contribute when funds were needed.

Federal Payments. The U.S. Treasury would make payments for several purposes. In particular, the government would be the main source of subsidies for low-income families, employers, and retirees. It would also finance a package of wraparound benefits for low-income children who were previously eligible for Medicaid, as well as pay the federal share of the restructured Medicaid program. In addition, funding would be required for program expansions such as Medicare's coverage of prescription drugs and initiatives such as home- and community-based services for severely disabled people.

The Role of State Governments and Alliances

Although the structure and standards for the proposed health care system would come largely from the federal government, the states and alliances would have the major responsibility for the day-to-day operation of the system. States would also have to help finance the new system.

Responsibilities of State Governments. Each participating state would be required to:

- Submit a document to the National Health Board describing the health care system the state proposed to establish;
- Establish one or more regional alliances, designating the geographic area that each alliance would cover;
- Ensure that families in each regional alliance had a choice of plans in which to enroll;
- Ensure that families were credited with any subsidies for their premiums to which they were entitled;
- Establish capital standards for health plans that met the federal requirements;
- Establish standards for financial reporting, auditing, and reserves of health plans;
- Establish the standards for certifying the health plans that regional alliances would offer, including criteria for quality, financial stability, and capacity to deliver the standard benefit package, and certify the plans to be offered;
- Establish a guaranty fund to pay claims and other debts in the event that a plan failed and, after a failure, collect an assessment of up to 2 percent on premiums to repay the obligations of the plan;
- Ensure continuity of coverage for enrollees in health plans that failed;
- Ensure that the amounts owed to regional alliances were collected and paid; and
- Assist regional alliances in establishing eligibility for subsidies of premiums and cost-sharing amounts and assume financial responsibility for errors that exceeded certain limits.

A designated state agency or official would be responsible for coordinating these activities at the state level.

States would also have substantial financial obligations. They would pay the regional alliances for their share of premiums for individuals and families who remained eligible for Medicaid, and they would be responsible for their share of Medicaid's spending on services not included in the standard benefit package for that group.

In addition, states would make maintenance-of-effort payments related to the restructured Medicaid program. Two components of these payments

would be on behalf of people who would lose their Medicaid coverage under the proposal. (Those people would no longer obtain coverage from the Medicaid program, but most of them would receive subsidies for their premiums for the standard benefit package.) One component would reflect 1993 expenditures for services in the standard package, and the other would reflect the part of states' payments to disproportionate share hospitals attributable to this group of people in that year. A third component would be based on fiscal year 1993 expenditures for children who remained eligible for Medicaid, excluding spending for services that would be in the standard package and for long-term care. The 1993 amounts would be updated by Medicaid-specific factors until the first year of a state's participation, and by the general health care inflation factor combined with the projected rate of growth in the population under age 65 thereafter.

Responsibilities of Regional Alliances. The regional alliances, by contrast, would not finance the health care system. Rather, they would serve as conduits of funds from the federal and state governments, employers, and families to health plans. They would be the frontline agencies that contracted with health plans, enrolled individuals and families in plans, and obtained and disseminated information on the performance of those plans. Regional alliances would also calculate the amounts that families and employers would have to pay, determine whether families and employers were eligible for subsidies, and collect payments from them. In addition, regional alliances would have to implement the cost control provisions required by the federal government. That would include establishing fee schedules for fee-for-service plans, unless the state elected to have a single, statewide fee schedule.

Regional alliances would also play an important role in collecting and analyzing data. They would, for example, have to estimate the number of workers in the different types of families; those numbers would be used in determining how much employers would have to pay. In addition, in order to determine the weighted average premium for each family type, each alliance would have to provide information to the National Health Board about the market shares of the different plans with which it had contracts.

All activities of the regional alliances would be paid for by an assessment on premiums. Each alliance would determine that level annually, but it could not exceed 2.5 percent of total premiums.

The Role of Employers and the Decision to Form a Corporate Alliance

Employers would have many of the same responsibilities whether they participated in a regional alliance or established a corporate alliance. In either case, employers would have to pay a portion of the premiums for their employees' policies. They would also have to deduct their employees' share of the premiums from their paychecks and transfer the funds to the appropriate alliance. In addition, all employers would have to provide specified information to their employees and to the regional alliances.

Most firms with 5,000 or fewer full-time employees would have to participate in regional alliances. (Some smaller firms might participate in multiemployer corporate alliances or ones established by rural electric and telephone cooperatives.) Larger firms, however, would have to decide whether to join a regional alliance or set up a corporate alliance after weighing the relative advantages and disadvantages of the two options. Firms would generally have to decide by January 1, 1996. A decision to participate in a regional alliance would be irrevocable; however, the decision to establish a corporate alliance could be reversed at a later date.

Advantages of Corporate Alliances. Large firms might choose to form a corporate alliance for several reasons. Firms that had already established effective programs for containing health care costs might think that they could control health spending better than the alliance system. Firms would also continue to have direct input into the quality of care their full-time employees received. In addition, they would not be responsible for the assessments that employers participating in regional alliances would

have to pay if there was a shortfall in premium payments. Finally, they would not have to pay the 1.5 percent assessment on premiums for graduate medical education and academic health centers that firms in regional alliances would pay. (Firms in multiemployer alliances would have to pay the 1.5 percent assessment, however.)

Disadvantages of Corporate Alliances. Despite the advantages of establishing a corporate alliance, significant disadvantages would predominate for many large firms. The most important one would generally be that firms that formed corporate alliances would have to pay a tax of 1 percent on their total payroll and that the tax would begin before the regional alliances were set up. (Firms participating in multiemployer alliances would not be subject to that tax.) Moreover, the effective rate of the tax on the payroll of full-time employees enrolled in plans offered by the corporate alliance would be higher than that, because the wages of part-time employees would be in the tax base but the employees would not be eligible to participate. (They would have to enroll in plans offered by the regional alliance, and the firms would have to make the appropriate payments to regional alliances on their behalf.)

Furthermore, a firm that established a corporate alliance would not be eligible for the cap on its premium payments that would be phased in if it joined a regional alliance. Moreover, its low-income employees who worked full time would not be eligible for governmental subsidies of their premiums, and the corporate alliance itself would generally have to subsidize premiums for full-time employees making less than $15,000 a year.[12] A firm that established a corporate alliance and chose to self-insure might also have to make periodic contributions (of up to 2 percent of annual premiums) to the insolvency fund established by the Secretary of Labor for self-insured health plans offered by corporate alliances.

Large firms that had self-insured in the past would probably experience considerably more regulation under the proposal. In addition to the federal requirements for health plans offered by corporate alliances that have already been discussed, the Secretary of Labor would specify financial reserve requirements that those alliances would have to meet. Their fee-for-service plans would have to use the same fee schedules as plans in their corresponding regional alliances. The growth rates of their premiums would be subject to essentially the same limits as those of the regional alliances. Finally, in addition to greater regulation, such firms might find themselves with relatively little power in markets dominated by large regional alliances.

Employers' Obligations for Retirees' Health Benefits. Regardless of whether they participated in corporate or regional alliances, all firms that were paying more than a specified threshold for retirees' health benefits on October 1, 1993, would continue to have obligations to those retirees and most of their dependents. When the subsidies for early retirees commenced in 1998, those employers would be required to pay 20 percent of the weighted average premium for the appropriate type of family. That obligation would continue only as long as members of that cohort remained eligible for the benefits of early retirees.

Because of the large financial windfall that firms with extensive obligations to retirees would gain under the proposal, all employers with health care costs for retirees aged 55 through 64 in 1991, 1992, or 1993 would also be subject to a temporary annual assessment. That assessment, which would be paid each year from 1998 to 2000, would equal one-half of either the average annual health care costs for retirees in the 1991-1993 period (increased by the medical care component of the CPI from 1992 on) or the estimated reduction in retirees' health care costs for the year—whichever was greater.

The Flow of Funds Through Regional Alliances and Health Plans

Regional alliances would receive funds from multiple sources, which they would then allocate to health plans and to other uses. The proposal specifies who would bear the financial responsibility in

12. No subsidy would be required if the employer's contribution covered at least 95 percent of the premium of the most economical plan that did not have higher cost sharing.

particular circumstances if outflows from alliances exceeded inflows.

Sources of Funds for Regional Alliances. Regional alliances would receive payments from the following sources:

- Payments (reflecting appropriate reductions because of subsidies) from employers;
- Payments (reflecting appropriate reductions because of subsidies) from families for the family share and, in some cases, for part or all of the equivalent of the employer share;
- Risk-adjustment payments from firms that were eligible to form corporate alliances but decided to join regional alliances;[13]
- Payments from corporate alliances for part-time employees and for employees in two-worker families who chose to participate in plans offered by regional alliances;
- States' payments for AFDC and SSI beneficiaries, who would make up the continuing Medicaid population;
- States' maintenance-of-effort payments, including those made on behalf of low-income people who would no longer be eligible for the restructured Medicaid program; and
- Federal payments for subsidies and for Medicare beneficiaries who were enrolled in plans offered by the regional alliances, as well as the federal share of Medicaid payments for AFDC and SSI beneficiaries.

Although Medicaid beneficiaries would be enrolling in plans offered by the alliances, Medicaid's payments to alliances on their behalf would not be related to the actual premiums of those plans. Rather, the payments would generally be 95 percent of what Medicaid would have paid in 1993 for the services in the standard benefit package, updated by Medicaid-specific inflation factors until the first year of the state's participation, and by the general health care inflation factor thereafter. (Those amounts would be estimated separately for the AFDC and SSI populations.)

Federal payments for subsidies would, in effect, be residual payments based on the difference between an alliance's payment obligations and amounts receivable from all other sources. As discussed below, however, the proposal specifies certain shortfalls between inflows and outflows that would not be considered federal responsibilities and would not be included in the calculation of those residual amounts.

Uses of the Regional Alliances' Funds. The funds of the regional alliances would be used primarily to make payments to health plans and to pay the alliances' administrative costs. Regional alliances would also pay the federal government 1.5 percent of total premiums in order to help the government finance academic health centers and graduate medical education. In addition, these alliances would make payments to corporate alliances for two-worker families who elected to enroll in a plan offered by the corporate alliance rather than in one offered by the regional alliance.

Health plans would not, however, receive their actual premium amounts. Instead, they would receive a per capita amount for each enrollee, that amount would be based on a weighted average of the final per capita premiums the plans had negotiated with the alliance and the amounts that Medicaid would pay for the AFDC and SSI populations. The weights would reflect the relative size of those populations in the alliance as a whole.

Regional alliances would also adjust the per capita amounts to reflect the risk status of each plan's enrollees. The risk adjustments would be designed to protect plans that enrolled people whose expected use of services was higher than that in the alliance as a whole. Risk adjustments could also be made for plans that enrolled disproportionate numbers of AFDC or SSI beneficiaries. Plans would, however, have to absorb part of the cost-sharing

13. If people who would have been covered by plans offered by the corporate alliance were at greater risk than others covered by the regional alliance's plans, the firm would pay risk-adjusted premiums for the first four years. That adjustment would be phased out during the next four years.

they would generally require of participants, because Medicaid beneficiaries would pay only a small portion of it.

Allocation of Risk for Administrative and Estimating Errors. The payment obligations of regional alliances could exceed their receipts for a variety of reasons. Short-term problems with cash flow could result from administrative problems, disparities in the timing of receipts and payments, and estimating errors.

The federal government would not accept financial responsibility for cash flow problems arising from administrative errors that exceeded certain limits; such errors would occur primarily in determining eligibility for subsidies. Alliances could borrow from HHS for shortfalls resulting from such errors, but the states--not alliances--would have to repay the loans through increases in their maintenance-of-effort payments.

Regional alliances could also borrow from HHS for shortfalls arising from disparities in the timing of payments and receipts or from errors in estimates of the factors used to determine their inflows and outflows. These factors would include the number of extra workers in couples and two-parent families, the proportion of AFDC and SSI beneficiaries in the alliance, the distribution of families in different risk categories, the amount of premiums that would not be collected, and, under certain circumstances, the distribution of enrollment in plans with different levels of premiums. The loans would be repaid through reductions in future federal payments to the alliance.

In the first year of operation, however, no alliance could borrow more than 25 percent of its estimated total premiums from HHS. In subsequent years, an alliance's total outstanding loan amount could not exceed 25 percent of its premiums in the previous year. The Secretary of the Treasury would be authorized to advance funds to HHS to cover loans to regional alliances, but the total balance of advanced funds could not exceed $3.5 billion at any time. Regional alliances would also be able to borrow in the private credit markets, but they would be prohibited from using tax-exempt financing.

Controlling Health Care Costs and Limiting the Financial Exposure of the Federal Government

Besides ensuring universal coverage, the other major goal of the Administration's proposal is to control the rate of growth of health spending and, as a corollary, to limit the financial exposure of the federal government. The proposal employs a two-pronged approach to controlling costs: reliance on market forces and, as a backstop mechanism, federal control of the level and rate of growth of premiums. It also attempts to limit federal payments to alliances for subsidies.

Market Forces and Cost Containment

Competition among health plans in a regional alliance is one mechanism through which the proposal intends to control costs. Under the proposal, however, health plans would compete on a different basis than they do today. Those in a regional alliance would not be able to compete on the basis of the benefits they offered, as do current plans, because they would all be required to offer the same standard package of benefits, including standardized cost sharing, to all their enrollees. Moreover, supplementary policies to cover additional services would generally have to be available to any applicant, subject to capacity and financial constraints. Plans would therefore compete on the basis of the quality and convenience of their services and on the level of their premiums.

Families purchasing health coverage through a regional alliance would have incentives to select less expensive plans because the payments that employers would have to make would be independent of the plans their employees selected. In principle, families with workers who selected plans with premiums above the weighted average in the alliance would have to pay more than 20 percent of the premium, and those selecting plans with premiums below the weighted average would pay less than 20

percent. (That might not always be the case because of other adjustments, such as subsidies for low-income families, or because the employer paid more than the minimum required.) Families for whom no employer was paying premiums, including nonretiree families with no workers, would also have strong incentives to choose plans with lower premiums. They would have to make a trade-off, however, if the lowest-cost plans had higher cost sharing.

Box 1-2.
Controlling the Level and Growth of Premiums

The controls on premiums would be implemented differently in regional and corporate alliances. The National Health Board would establish the initial maximum per capita premium that would be permitted in each regional alliance; it would also set limits on its growth. In contrast, corporate alliances would experience controls only on the rate of growth of their premiums.

Setting Initial Premiums for Plans in Regional Alliances

The following steps describe the process for establishing and enforcing the initial level of premiums for regional alliances in states that chose to enter the system in 1996.[1]

The National Health Board would set a baseline target for the national per capita premium based on expenditures for the standard benefit package in 1993. These expenditures would, however, exclude spending for groups such as beneficiaries of Aid to Families with Dependent Children, Supplemental Security Income, and Medicare.

The target would also reflect expected increases in use of services by people who were uninsured or had coverage that was less comprehensive than the standard benefit package, declines in uncompensated care, anticipated reductions in use resulting from higher cost sharing, and cost-sharing amounts that would be required for services covered by the standard package. It would also include an allowance of up to 15 percent to cover the administrative costs of health plans and alliances and existing state taxes on premiums for health insurance. The board would inflate the 1993 national baseline target to 1995 using an inflation factor based on the rate of increase of health spending by the private sector but not more than 15 percent over the two-year period.

By the beginning of 1995, the board would adjust the 1995 national baseline target to establish a target for each regional alliance that would be operating in 1996. The adjustments would account for variations among alliances in health spending, insurance coverage, and spending by academic health centers. To obtain the 1996 targets, the baseline amount would be increased by each alliance's inflation factor. That factor would be the general health care inflation factor adjusted to reflect changes between 1995 and 1996 in the health status and demographic characteristics of each alliance relative to changes in the nation as a whole.

Health plans in a state that was planning to start participating in 1996 would then submit their bids for the per capita premium to each regional alliance in which they wished to operate. Each plan's bid would reflect its estimate of the average per capita premium for the standard benefit package in a particular alliance. Plans submitting bids would do so with the understanding that the board could, under circumstances described below, subsequently lower their bids, and they would have to accept any such reduction.

Following a negotiation period during which health plans might voluntarily lower their bids, each regional alliance would submit its final bids for the per capita premium from their health plans to the National Health Board for review. The board would use information from the alliance to estimate its weighted average bid; each plan's bid would be weighted by the expected enrollment in that plan. The result for each alliance would then be compared

1. A similar process would be followed for alliances that began in 1997 or 1998.

Comparison shopping by consumers would be easier because the regional alliances would provide information about factors such as the quality of care provided by each plan, and consumers would no longer be concerned about differences in benefit packages that were hard to detect. Annual open-enrollment periods would also facilitate moving out of plans that consumers found unsatisfactory.

with the target for that alliance's per capita premium.

If the weighted average bid exceeded the target for the alliance, the board would notify the alliance that it was not in compliance. It would also notify all plans whose bids were above the target that they would face compulsory reductions in their per capita premiums if they did not lower them voluntarily. The reductions would be a percentage of the amount that their bids exceeded the target and would be designed to lower the weighted average bid to the target. Plans with bids under the target would not be affected.

Any plan that chose not to lower its bid voluntarily would have its per capita premium--that is, the amount that would determine its funding from the alliance--reduced by the board. As a consequence, the plan would be required to lower its payments to providers. Those cuts in payments would reflect the proportional reduction in the plan's premium, adjusted for the anticipated increase in the volume of services that would result from the lower payments.

Limiting the Growth of Premiums

After its first year of participation, a regional alliance's target for the per capita premium would be the target for the previous year updated by that alliance's inflation factor. This inflation factor could differ in two ways from the definition used in the initial year. First, it would reflect any changes in the demographic characteristics of the regional alliance that occurred because a corporate alliance had terminated and its members had enrolled in the regional alliance. A second adjustment would occur if the actual per capita premium for the alliance exceeded its target in any year as a result of more people enrolling in high-cost plans than expected. In this case, the alliance's inflation factor would be reduced for the next two years so that health spending in the alliance would be reduced during the two-year period by enough to offset the higher expenditures made in the previous year.

After the initial year, changes would also be made in the procedure for determining the amounts by which bids for the per capita premium would be reduced for a regional alliance that did not comply with its target. To determine the extent to which a plan's bid was too high, the board would compare the current bid with the following amount: the previous year's bid plus the premium target for the current year, less either the premium target or the weighted average bid, if that was lower, for the previous year.[2] Bids submitted by new plans would be compared with the target for the alliance's per capita premium. The remainder of the procedure would be the same as in the initial year.

For corporate alliances, the cap on the rate of growth of premiums would be based on a comparison of the rate of growth of the three-year moving average of per capita spending with the rate of growth of the three-year moving average of the general health care inflation factor. In 2001, corporate alliances would have to start reporting their average per capita expenditures for the previous three years to the Secretary of Labor. If the rate of growth of the spending measure exceeded the rate of growth of the inflation measure in two years out of three, the alliance would be terminated and its members would enroll in plans offered by their regional alliances.

The board also would estimate targets for per capita premiums for single-payer states. If per capita spending for the standard benefit package in those states exceeded the targets, the states would be required to reduce payments to providers accordingly.

2. In the event that the plan's bid for the previous year had been reduced involuntarily, the amount of that reduction would also be subtracted.

Furthermore, limiting the exclusion of employer-paid insurance premiums from employees' income would heighten consumers' awareness of costs once the new system was fully phased in. Employer-paid premiums would be excluded until 2004, however, and then only employer-paid premiums for policies covering additional services would be included in employees' taxable income. Moreover, the proposal would substantially expand the income tax subsidy for premiums paid by the self-employed, further limiting the effectiveness of market forces in containing costs.

Controls on the Level and Rate of Growth of Premiums

To supplement the effects of market forces in containing health care costs, the proposal includes provisions for federal control of premiums for the standard benefit package. The principle underlying the proposed controls is that the national per capita premium for the standard benefit package should increase each year by no more than the general health care inflation factor. For the period from 1996 through 2000, the values of that factor would be the increase in the CPI plus specified amounts--1.5 percentage points in 1996, 1.0 percentage point in 1997, 0.5 percentage point in 1998, and zero in 1999 and 2000. After 2000, if the Congress did not specify new inflation factors, the default factor would be the percentage increase in the CPI combined with the percentage growth in real GDP per capita. (Adjustments would also be made in 2001 to account for at least a portion of the increase in the actuarial value of the benefit package that would occur in that year.)

How the controls would be implemented would differ somewhat in regional and corporate alliances. The National Health Board would establish both the initial maximum per capita premium that would be permitted in each regional alliance and the limits on its growth. Corporate alliances, however, would experience controls only on the rate of growth, not the initial level, of their premiums. Box 1-2 (on pages 22 and 23) describes the processes that would be used to set the targets for regional and corporate alliances, as well as the consequences of breaching the targets.

Limits on Federal Payments to Alliances

In a further attempt to limit the federal government's financial exposure, the proposal lists maximum total federal payments to alliances of the following amounts: $10.3 billion in fiscal year 1996, $28.3 billion in 1997, $75.6 billion in 1998, $78.9 billion in 1999, and $81.0 billion in 2000. After 2000, the limit would be the previous year's limit inflated by the increase in the CPI combined with the average annual percentage change in the population for the previous three years and the average annual increase in real GDP per capita for the previous three years.

The proposal also includes the procedures to be followed if federal payments to alliances were expected to exceed the limits. In particular, the President would have to recommend to the Congress policies to resolve the conflict. The proposal also states that these recommendations would be considered in an expedited manner and would not be subjected to the routine procedural hurdles that tend to slow Congressional consideration of legislation. Because the Congress has the constitutional right to make and change its own rules, however, procedural mechanisms cannot guarantee that an issue will be considered. If the Congress took no action the courts might be asked to decide which portion of the legislation took precedence--payments to the alliances to ensure coverage of the specified benefits or the limits on federal payments.

Chapter Two

Financial Impact of the Proposal

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

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

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

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

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

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

How the Proposal Affects National Health Expenditures

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

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

Source of Funds	1996	1997	1998	1999	2000	2001	2002	2003	2004
				Baseline					
Private	614	661	712	766	824	886	952	1,022	1,095
Public									
Federal	379	416	460	505	555	610	670	735	807
Health alliances	0	0	0	0	0	0	0	0	0
State and local	169	184	200	216	234	253	273	295	318
Total	1,163	1,263	1,372	1,488	1,613	1,748	1,894	2,052	2,220
				Changes from Baseline					
Private	-59	-157	-387	-422	-460	-510	-554	-601	-650
Public									
Federal	5	-6	-49	-68	-78	-84	-93	-106	-127
Health alliances	74	208	542	563	585	635	668	703	740
State and local	-7	-23	-66	-72	-78	-90	-97	-105	-114
Total	13	22	40	1	-30	-48	-75	-110	-150
				Administration's Proposal					
Private	555	505	325	344	363	376	398	422	446
Public									
Federal	384	412	411	437	478	526	577	627	681
Health alliances	74	208	542	563	585	635	668	703	740
State and local	162	161	134	145	157	163	177	190	204
Total	1,176	1,285	1,411	1,489	1,583	1,700	1,820	1,942	2,070

SOURCE: Congressional Budget Office.

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

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

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

How the Proposal Affects On-Budget Programs and Social Security

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

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

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

Health Insurance Premiums

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

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

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

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

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

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

Table 2-2.
Continued

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

SOURCES: Congressional Budget Office; Joint Committee on Taxation.

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

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

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

a. Less than $500 million.

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

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

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

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

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

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

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

Corporate Alliances

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

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

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

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

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

Subsidies for Employers

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

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

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

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

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

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

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

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

Subsidies for Families

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

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

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

Total Federal Subsidies

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

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

Changes in Medicare

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

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

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

SOURCE: Congressional Budget Office

NOTE: GDP = gross domestic product, SMI = Supplementary Medical Insurance

a. Less than $500 million.

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

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

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

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

Changes in Medicaid

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

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

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

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

Long-Term Care Benefit

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

Changes in Other Federal Programs

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

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

Changes in Revenues

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

How CBO's Estimates Compare with Those of the Administration

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

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

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

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

a. Less than $500 million.

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

Subsidies for Employers

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

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

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

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

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

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

Other Differences

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

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

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

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

Sensitivity of the Estimates to Premium Levels

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

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

Table 2-8.
Sources and Uses of Funds of the Health Alliances
(By fiscal year, in billions of dollars)

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

SOURCE Congressional Budget Office

a Less than $500 million

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

Sources and Uses of Funds of the Health Alliances

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

Chapter Three

Budgetary Treatment of the Proposal

The *Budget of the United States Government* serves many purposes. Not only is the budget a financial accounting of the receipts and expenditures of the federal government; it also sets forth a plan for allocating resources--between the public and private sectors and within the public sector--to meet national objectives.

Ever since the outlines of the Administration's health proposal became known, policymakers and the media have expressed considerable interest in how it would be treated in the federal budget. Some observers contend that the program would not receive an appropriate degree of scrutiny if the budget did not include all of its financial transactions. If the financial activities mandated by the new program were not part of the budget, they argue, fiscal discipline might suffer: activities that are now in the budget might be transferred to nonbudget entities that were not subject to the oversight and restraints characteristically imposed on budget accounts. Others fear that labeling all of the program's financial flows as budgetary might preclude a reasoned consideration of the proposal's merits by raising concerns about the size of the public sector. The choice of budgetary treatment could also affect which Congressional committees are given primary jurisdiction over the proposal.

The issue of budgetary treatment is not peculiar to the health reform initiative. Every time the Congress considers or enacts a bill that establishes a new program, the Congressional Budget Office and the Office of Management and Budget must consider whether and how it should be shown in the federal budget. For most pieces of legislation, this is a relatively easy call. But for some bills, such as major health reform proposals, that assessment is marked by some ambiguity and considerable complexity.

This chapter discusses the appropriate budgetary treatment of the Administration's health proposal, particularly the treatment of the payments to and from the regional and corporate alliances. It first examines the two main sources of guidance on budgetary classification--the *Report of the President's Commission on Budget Concepts* and the current budgetary treatment of programs analogous to the President's plan. It finds that these sources can inform the decision on how to treat the Administration's proposal but by themselves cannot resolve the issue.

The second and third sections of this chapter explain CBO's view: the financial transactions of the health alliances should be included in the accounts of the federal government, but they should be distinguished from other federal operations and shown separately, as is the practice for the Social Security program. CBO bases this view primarily on its judgment that the Administration's proposal would establish a federal entitlement to health benefits and that the mandatory premiums used to finance the new entitlement would constitute an exercise of sovereign power. CBO's view on these matters is only advisory; ultimately, the Congress and the President should explicitly address the issue through legislation to ensure the appropriate public control of and accountability for the transactions of the alliances.

Guidelines for Budgetary Classification

Certain elements of the Administration's proposal are unambiguously federal activities that all agree should be included in the budget--for example, the increase in the tax on tobacco, the subsidies for individuals and employers, the expansion of certain discretionary programs, and the changes in Medicare and Medicaid. But what about the premiums that individuals and employers pay to the health alliances and the payments by the alliances to the various health plans? Are the alliances private or state entities that belong outside the federal budget? Or are they, for most practical purposes, creatures of the federal government, whose income and outgo should all be included in the federal government's accounts?

In answering such questions, budget analysts normally consult two sources for guidance. One is the 1967 *Report of the President's Commission on Budget Concepts*. The other is budgetary precedents. Because of the unique features of the Administration's health proposal, neither source provides an unambiguous answer.

The President's Commission on Budget Concepts

In March 1967, President Lyndon B. Johnson appointed a 15-member commission to advise him on budgetary concepts and presentation. The commission issued its report in October of that year, and the budget that the President submitted in January 1968 reflected most of its recommendations--notably, the institution of a unified federal budget. The commission's proposal to record federal credit transactions in the budget on a subsidy-cost basis was not adopted until 1990, with the passage of the Federal Credit Reform Act. A few recommendations--for example, the use of accrual accounting instead of cash accounting--have never been fully implemented.

Although the *Report of the President's Commission on Budget Concepts* has no legal status, it remains to this day the only authoritative statement on federal budgetary accounting. The commission's most important recommendation was for a comprehensive budget with few exclusions. "To work well," the commission stated, "the governmental budget process should encompass the full scope of the programs and transactions that are within the Federal sector and not subject to the economic disciplines of the marketplace." The commission recommended that "the budget should, as a general rule, be comprehensive of the full range of Federal activities. Borderline agencies and transactions should be included in the budget unless there are exceptionally persuasive reasons for exclusion."[1]

The commission recognized that its recommendation posed "practical questions as to precisely what outlays and receipts should be in *the budget* of the federal government. The answer to this question is not always as obvious as it may seem: the boundaries of the federal establishment are sometimes difficult to draw." The commission proposed a series of questions to help make this determination: "Who owns the agency? Who supplies its capital? Who selects its managers? Do the Congress and the President have control over the agency's program and budget, or are the agency's policies the responsibility of the Congress or the President only in some broad ultimate sense? The answer to no one of these questions is conclusive, and at the margin where boundary questions arise, decisions have been made on the basis of a net weighing of as many relevant considerations as possible."[2]

The report cited some exceptions, though to its recommendation of a comprehensive budget. For example, even though the Federal Reserve System is clearly a federal operation, the commission recommended that its receipts and expenditures be excluded from the budget, in part to protect the independence of the nation's monetary authorities. The commission recommended that the local receipts and expenditures of the District of Columbia be excluded as well, even though the District is a federal

1. *Report of the President's Commission on Budget Concepts* (October 1967), pp. 24-25.

2. Ibid.

enclave. The commission further recommended that government-sponsored enterprises be omitted from the budget when such enterprises were "completely privately owned." Because the Administration's proposal shares some of the characteristics of these exceptions but lacks others, no one can be sure how the commission would have treated the health alliances, had they been on the horizon in 1967.

The commission also considered the issue of when to offset receipts against expenditures in presenting the government's fiscal totals. For fiscal year 1993, the Department of the Treasury reported federal outlays of $1,408 billion, federal governmental receipts of $1,153 billion, and a deficit of $255 billion. The figure for governmental receipts includes most of the funds that the government collects (for example, income and payroll taxes). But the budget treats some of the government's income, such as proceeds from the sale of stamps by the Postal Service, as an offset to its outlays.

"For purposes of summary budget totals," the commission recommended, "receipts from activities which are essentially governmental in character, involving regulation or compulsion, should be regarded as receipts. But receipts associated with activities which are operated as business-type enterprises, or which are market-oriented in character, should be included as offsets to the expenditures to which they relate." Among the various items that should be treated as budget receipts the commission listed both employment taxes and social insurance premiums.[3]

Budgetary Precedents

Another way to inform judgment is by examining relevant precedents. Yet this approach is also incomplete, because the Administration's health proposal differs significantly from existing programs and because existing accounting practices are inconsistent.

In one major instance--the unemployment insurance (UI) program--the federal budget includes in its entirety a joint activity of the federal and state governments. The Social Security Act of 1935 created the UI program and established a federal tax liability. Under the program, states are free to set tax rates, benefit levels, and eligibility requirements within certain limits. States that establish a federally approved UI system and impose their own payroll tax receive a partial credit against the federal UI tax. The federal tax pays for federal and state administration of unemployment insurance, 97 percent of the cost of employment services, and 50 percent of the cost of extended benefits during periods of high unemployment in a state. The state and federal taxes alike are deposited in trust funds held by the U.S. Treasury, and the federal budget records all of the funds' revenues and spending.

In other instances, the federal budget includes only part of the cost of a joint federal/state program. For example, if a state establishes a program of Medicaid or Aid to Families with Dependent Children that meets the terms of the Social Security Act, the federal government pays a prescribed share of the costs, and the budget includes only that federal payment. Unlike the case of unemployment insurance, however, the federal government imposes no tax or other penalty if a state fails to establish a Medicaid or AFDC program.

The Coal Industry Retiree Health Benefit Program is part of the federal budget, although its funds do not pass through the Treasury. Established by the Energy Policy Act of 1992, this program guarantees lifetime health benefits for certain miners and their dependents and requires coal companies to pay health insurance premiums to two privately managed trust funds on behalf of those miners, including some who never worked for the companies in question. Even though the benefit plans are nominally private and the federal government plays no role in selecting their trustees, the plans' receipts and spending are included in the federal budget because federal law both requires payment and determines the use of the money.

The budgetary treatment of the promotional boards for agricultural commodities is at odds with that of the Coal Industry Retiree Health Benefit Program. Federal law has established 17 of these boards since 1955. The boards collect assessments

3. Ibid., p. 65

from domestic producers (and sometimes importers and marketers) and use those funds to promote consumption of a particular commodity, such as dairy products or cut flowers. The Secretary of Agriculture appoints most of the boards, and federal law establishes and enforces payment of the assessments. Yet despite this substantial federal role, the budget does not include the transactions of the boards.

Still other comparisons are possible between the Administration's proposal and various federal regulatory activities. For example, the federal government requires employers to meet conditions governing the wages and hours of workers (under the Fair Labor Standards Act of 1938), occupational safety and health (under the Occupational Safety and Health Act of 1970), and the treatment of persons with disabilities (under the Americans with Disabilities Act of 1990). All of these laws impose substantial costs on employers and may affect the amount and type of compensation that employees receive, but the budget includes none of their costs.

Looking at these budgetary precedents does not resolve the issue of how to treat the Administration's health proposal. The proposal bears a resemblance to all of the programs cited, but it also shows significant differences. Which is the most appropriate comparison? Is the proposal most like the unemployment insurance program, AFDC or Medicaid, the Coal Industry Retiree Health Benefit Program, the promotional boards for agricultural commodities, the mandates of the Americans with Disabilities Act, or some other program? The answer is, again, a matter of judgment. But even if the answer were clear, a practice followed for a program costing $200 million might not be appropriate for one costing $500 billion.

CBO's Assessment

Determining the appropriate budgetary treatment of a program like health reform involves answering not one but a series of questions. Is the program fundamentally governmental in nature, or does the legislation seek to facilitate, regulate, or guide an activity or transaction that remains essentially private? If the activity is primarily governmental, is it a federal activity, a state activity, a shared federal/state activity, or some new hybrid? If the answers to these two questions indicate that the program belongs in the accounts of the federal government, a third question arises: How should the program be displayed in, and controlled through, the budget?

Considering the Administration's proposal in its entirety, the Congressional Budget Office concludes that it establishes both a federal entitlement to health benefits and a system of mandatory payments to finance those benefits. In administering the proposed program, regional alliances, corporate alliances, and state single-payer plans (if any) would operate primarily as agents of the federal government. Therefore, CBO believes that the financial transactions of the health alliances should be included in the federal government's accounts and that the premium payments should be shown as governmental receipts rather than as offsets to spending. Nonetheless, because of the uniqueness and vast size of the program, the budget document should distinguish the transactions of the alliances from other federal operations and show them separately, as is the practice for Social Security. CBO's view, as noted earlier, is solely advisory. The President and the Congress should ultimately resolve the debate over the proposal's budgetary treatment through legislation.

Why Should the Health Alliances Be Included in the Accounts of the Federal Government?

Two factors shape CBO's view that the proposed health alliances should be included in the federal government's accounts—a review of budgetary concepts and precedents and the need to ensure fiscal accountability and control. In addition, the public's perception of the nature of the new program deserves some consideration.

Budgetary Concepts and Precedents

More than a government regulation, the Administration's proposal specifies outcomes, dictates the means by which the outcomes must be achieved, prescribes the financing mechanism that must be used, and enforces the prescribed transactions. The first section of Title I creates a universal entitlement to a set of benefits that are defined in considerable detail. The benefits would not be restricted to those who already receive similar benefits, nor would nonpayment of premiums be grounds for a health plan or health alliance to deny benefits. Thus, the program does more than redefine the terms or conditions of preexisting private transactions, which is how one might characterize the minimum wage, for example.

The Administration's proposal establishes an explicit financing mechanism for the standard benefit package. It requires employers (except those large firms that choose to form corporate alliances), employees, and nonworkers to pay premiums to the regional alliances. A federal entity--the National Health Board--and a set of subsidies specified in federal law would largely determine the levels of those payments. The premiums would be mandatory, although many participants would undoubtedly pay them gladly in return for the program's health benefits, just as many would voluntarily contribute to Social Security in return for that program's retirement, survivors, and disability benefits. The proposal would also require states to make specified payments (for example, Medicaid maintenance-of-effort payments) to their regional alliances.

The National Health Board and the Departments of Health and Human Services and Labor would play important roles in the creation and day-to-day operation of the new health system. The board would approve the states' health care systems, impose sanctions on those systems that failed to meet federal requirements, develop a methodology for risk adjustment and reinsurance, set capital standards for health plans in the regional alliances, develop standards for states' guaranty funds, and oversee and monitor the system. The Secretary of Health and Human Services would develop standards for the financial management of the health alliances, audit the regional alliances, and certify essential community providers with whom plans would have to affiliate. The Secretary of Labor would be responsible for the proper functioning of the corporate alliances and could impose civil monetary penalties for noncompliance.

Although the federal government would play a very large role, the proposal would assign substantial responsibilities--and leave some discretion--to the states, the regional alliances, corporations, and individuals. States would establish and define the geographic boundaries of the regional alliances, ensure that the amounts owed to the alliances were collected and paid, assist alliances in verifying eligibility for subsidies, certify health plans and assure their fiscal solvency, ensure that all residents had access to an adequate choice of health plans, establish a reinsurance program for health plans, and provide a guaranty fund. If they chose, states could assign the responsibilities of the alliances to a state agency. They could also establish a single-payer plan, which would affect the amount of choice offered to the state's residents, the governance of the system, and (within specified limits) the system's financing.

The regional alliances would be charged with making agreements with qualified health plans and offering those plans to the residents of their areas. The alliances would ensure that people enrolled in health plans, collect premiums, determine eligibility for subsidies, evaluate the performance of health plans, ensure that the plans stayed within budget, adjust payments to plans for different levels of risk, establish fee schedules for services, and coordinate activities with those of other alliances. In addition, health plans in the regional alliances would offer participants the option of purchasing supplementary insurance to cover certain cost-sharing requirements of the standard benefit package and could offer supplementary insurance for items not included in the standard package. As proposed, the alliances' income from premiums and their payments to the health plans would not pass through the Treasury's accounts.

Large corporations would be able to establish corporate alliances that would perform the basic functions of regional alliances. Large corporations would also have some discretion in shaping the

options that their corporate alliances offered to employees. The Administration's proposal would impose no limits on the amount a corporation could initially pay for the insurance it provided to its workers, but it does specify the minimum fraction of the costs that the firm would have to pay and the rate by which premiums could grow. The premiums and payments would not flow though the regional alliances, and the subsidies to individuals would be largely the responsibility of the corporation, which would be required to pay at least 95 percent of the costs of insuring its low-wage workers. The proposal would require corporate alliances to offer at least three health plans (including one fee-for-service plan and two others, such as health maintenance organizations), employ community rating, use the same medical fee schedules as the regional alliances, and satisfy much the same requirements for information as the regional alliances.

Individuals in both regional and corporate alliances would have a choice of health plans, and their premiums would vary according to the plan they chose and their income. People would also have the option of purchasing supplementary health insurance.

Are these discretionary aspects of the proposal sufficient to classify the new program as a regulatory activity or a shared federal/state program? The answer to this question is a matter of judgment. No sharp line separates regulatory activities that are outside the budget from governmental activities that are within it. In this case, when the federal government specifies not only an outcome but also how the outcome is to be achieved, limits the ways in which the activity can be financed, makes a substantial financial contribution, and calls for the creation of new institutions to carry out the activity, CBO concludes that the boundaries of regulation have been crossed.

In particular, this appears to be the case with respect to the regional alliances. Federal statute would establish and define these new institutions. The terms and financing of the insurance they offered would be specified by federal law, and their activities would be regulated and monitored by the Departments of Labor and Health and Human Services. This situation differs from cases in which the federal government requires existing institutions--states or businesses--to take on added responsibilities and leaves open the choice of how they would finance them.

The corporate alliances, which have many of the characteristics of private entities, would for all practical purposes be standing in for a governmental or quasi-governmental agency--the regional alliance. If a large corporation chose not to establish its own alliance, it would have to participate in the regional alliances. If a corporate alliance did not comply with federal regulations or became financially insolvent, it could be terminated by the Secretary of Labor. If a state chose to establish a single-payer system, it could deny the large corporations operating within its borders the option of establishing a corporate alliance.

The important role and flexibility afforded to states and regional alliances do not appear to be sufficient to classify the proposal as a shared federal/state program like AFDC or Medicaid. Indeed, the level of federal involvement would far exceed that of existing entitlement grant programs. Regional alliances would be able to borrow from the federal government and would receive start-up grants from Washington. In addition, they would be granted powers that could only flow from federal authority. For example, they would have the power to extract premium payments from businesses in other states that employed their residents, even when those businesses engaged in no activity in the alliance's state. Federal law would establish a complex set of financial flows among alliances. Those flows would cover people who moved either temporarily or permanently, full-time students who attended schools located in other alliance areas, and multiworker families in which one or more workers could be covered by a corporate alliance.

As described in Chapter 1, federal agencies would play an important role in ensuring that states and alliances fulfilled the requirements specified in the proposal. If a state did not establish a system of alliances according to the law, or if the National Health Board terminated its approval of a state's system, the Secretary of Health and Human Services would establish and operate a system of alliances and would impose a surcharge of 15 percent on

premiums to cover additional administrative and other expenses. This backstop is even stronger than the one in the unemployment insurance program, which establishes a federal payroll tax liability that can be largely offset by state unemployment payroll taxes.

The universality of the entitlement distinguishes the Administration's health proposal from programs such as AFDC and Medicaid. In those two programs, states have the option of not participating. (Until 1982, Arizona did not participate in Medicaid.) The Administration's proposal would require everyone to participate; it would also require states to make specific payments to their regional alliances for noncash beneficiaries of Medicaid and for additional benefits for certain children receiving AFDC or Supplemental Security Income.

The significant financial role that payments from the U.S. Treasury would play in the new program reinforces the impression that it would be predominantly a federal, not a state, activity. By 2004, about 30 percent of the payments to the health alliances would be federal subsidies to low-income families and employers, payments for Medicaid beneficiaries, and the like. And the financial role of the Treasury in the regional alliances could grow even bigger if many Medicare recipients and military dependents currently receiving federal health services chose to participate in the alliances instead. In contrast, the states would have a much smaller financial role.

Even the voluntary aspects of the new program do not by themselves resolve the issue of budgetary treatment. The fact that individuals could choose the plan they wanted, and thus the premium they would pay, is balanced by the constraints that federal law and regulation would place on the benefits and the charges. The benefits and cost sharing would be set by legislation, and ultimately the National Health Board would limit the average premium in each area. The voluntary nature of supplementary cost-sharing insurance--people can decide whether or not to purchase it--must be weighed against the fact that federal law would define its scope, coverage, and availability. Moreover, the proposal would require that the premiums for cost-sharing supplements take account of the increased use of standard benefits by those people who had purchased the supplementary coverage. Furthermore, it is worth noting that the federal budget includes many voluntary transactions, not the least of which is physician insurance under Medicare.

On balance, the new program seems to represent an activity of the federal government that relies on the exercise of sovereign power. The universality of the entitlement, the mandatory nature of the premiums, and the major financial participation of the U.S. Treasury outweigh other considerations. Although the states and the alliances would have important roles and responsibilities, they would be acting largely as agents of the federal government.

Fiscal Accountability and Control

The second reason for including the health alliances in the federal government's accounts is the need for accountability and control. Since the alliances would be agents of the federal government, their financial flows should be subject to a level of oversight and control similar to that accorded programs that are included in the federal budget.

It is particularly important that the activities of the health alliances be subject to some fiscal restraints and limits as long as tight controls govern other federal activities. Discretionary appropriations are currently limited by caps on budget authority and outlays. Receipts and direct spending programs are constrained by pay-as-you-go rules. Social Security, which is classified as off-budget, is subject to its own set of rules, which are designed to prevent the depletion of the program's reserves.

The Administration's health proposal would establish many financial flows between the Treasury and the health alliances. Payments would flow from the Treasury to the alliances for subsidies to individuals and employers, for recipients of cash welfare benefits, and for Medicare beneficiaries who chose to stay in an alliance plan. The Treasury would receive payments from the alliances for graduate medical education and for participants who chose to get their health care through plans established by the Department of Defense, Department of Veterans Affairs, or Indian Health Service. If the

activities of the health alliances were not subject to fiscal control, the restraints on federal spending and receipts could easily be circumvented by altering these financial flows or creating new ones.

For example, the Congress could lower the mandatory payments that the federal and state governments would make to the alliances to pay for the health benefits of Medicaid cash beneficiaries from 95 percent of their previous payments to, say, 75 percent. If the alliances were exempted from the budgetary discipline imposed on most other federal activities, cutting those payments would appear to reduce federal spending and would add room on the pay-as-you-go scorecard, even if individuals and employers were required to pay higher health insurance premiums to cover the receipts lost to the alliances.

Similarly, the Congress could require health plans to cover needs and activities that are currently provided through discretionary appropriations, such as nutritional assistance for infants and pregnant women. This move would free up resources under the discretionary spending limits of the budget and make the health alliances bear added burdens if they were not subject to appropriate budgetary controls.

Increasing the limits on the percentage of their payrolls that employers contributed to the regional alliances would appear to have very different effects on the federal government's finances depending on how the budget treated the alliances. If the alliances were included in the government's accounts, higher employer payments would be recorded as an increase in governmental receipts. If the alliances were excluded, any rise in employers' payments would be shown as a spending cut, because it would reduce federal subsidies to the alliances.

Preventing budgetary gamesmanship requires that corporate alliances and state single-payer plans—not just regional alliances—be included in the federal government's accounts. Otherwise, legislation could create the semblance of budgetary savings by expanding the corporate alliances or by creating additional incentives for states to operate single-payer systems. Including the corporate alliances and the state plans would also avoid meaningless changes in the fiscal totals that could arise if several large firms terminated their corporate alliances or if the Secretary of Health and Human Services was forced to take over a state's system of alliances.

The Congress has several options available for controlling the financial activities of the health alliances. It could subject the alliances to the same fiscal controls that govern the rest of the federal government's activities, or set up a separate set of controls for them, or both. Without a full accounting and some sort of control, however, the income and outgo of the health alliances would escape the scrutiny that is essential when the federal government takes resources from individuals and businesses and uses them to meet a national objective.

Public Perception

Some policymakers and citizens may wonder whether including the health alliances in the federal government's accounts defies common sense and the public's perception of the nature of the new program. Why should the government's accounts show transactions that, for most workers, are like those that already occur in the private sector? The answer is that the budgetary status of a federal activity is not determined by whether the private sector provides the same service. Very few federal programs would be included in the budget if the criterion for inclusion were that there be no comparable private spending. Many federal programs that appear in the budget are largely an extension of prior practices in the private sector. For example, loans to businesses and individuals, medical research, and public safety programs are a few of the large number of federal programs that have displaced private spending to some degree.

Many of those people who now have employment-based health insurance might be surprised at first to be told that they had just become participants in a major new federal program, since under the new system they might be able to keep the same health plans that they now have and might enjoy much the same benefits. Currently, employers (or unions) make payments to insurance carriers that reflect both the employers' contributions and the employees' premiums (if any), which are deducted

from the workers' paychecks. In the new system, employers would make the same sorts of payments, but they would make them to an alliance, which would then transfer funds to the health plans that the workers had chosen.

What would differ is that federal law rather than the employer would determine the benefits and premiums. Moreover, the transaction would no longer be voluntary. The employer could not drop or change the terms of the health insurance benefit. Similarly, employees could not opt out of their employment-based plan, as some do now because they do not want to pay their share of the premium or because they are covered under a spouse's policy.

Those people who were receiving employment-based health insurance for the first time would initially be more accepting of the notion that they had become participants in a government program. Their employers, who would suddenly find themselves required to make payments for their employees' health insurance, would undoubtedly feel the same way. Many nonworking and self-employed individuals with adequate incomes who currently choose to remain uninsured would probably conclude that they were part of a government program as well.

Why Should the Health Alliances Be Shown Separately?

Although CBO's analysis has concluded that the health alliances would be more like federal agencies than like state or private entities, it has also found that the Administration's proposal would be unique in its form, size, scope, and complexity. In addition, the funds earmarked for the health alliances are not intended to be used for any other federal program. These features of the proposal argue for showing its transactions separately in the federal government's accounts rather than mixing them with other federal activities.

The institutions and responsibilities that the Administration's proposal would create would be unlike those of any existing federal program. The flows of premiums and spending into and out of the alliances would dwarf the income and outgo of Social Security, which is currently the largest federal program (see Table 2-5). The complexity of the structure would be unprecedented, with regional alliances, corporate alliances, and possibly state single-payer plans interacting with each other and with numerous private health plans, Medicare, Medicaid, the Veterans Affairs and Indian health systems, the Defense Department's health plans for military dependents, and the federal subsidy system. A separate budgetary accounting would make clear the size of the program and its effect on federal receipts and outlays.

Like Social Security, which is treated as off-budget but included in the federal government's consolidated accounts, the Administration's health proposal would be financed from earmarked revenues, except for the subsidies and other explicit payments from the U.S. Treasury and the states. Segregating the finances of the alliances from other federal programs would reflect the earmarked nature of the premiums and highlight the additional subsidies required.

Several practical considerations constitute further grounds for segregating the finances of the health alliances. Unlike the funds of almost all other federal programs, those of the alliances would not flow through the U.S. Treasury. At least initially, then, their financial data--particularly the reports from the corporate alliances--are likely to be of poorer quality than those of programs currently in the budget. The Coal Industry Retiree Health Benefit Program illustrates this point: despite its being in the budget, its funds do not pass through the Treasury, and problems with data collection have thus far prevented its inclusion in the *Monthly Treasury Statement of Receipts and Outlays of the United States Government*.

Table 3-1 illustrates the budgetary display that CBO suggests for the Administration's proposal. Federal outlays for premium and cost-sharing subsidies, Medicare, and Medicaid, and federal receipts from income and excise taxes (see Table 2-2) would be shown on-budget. Changes in Social Security benefits and payroll taxes would be shown off-

budget. The net outlays and nonfederal receipts of the health alliances (see Table 2-5) would be shown in a new off-budget category, the way Social Security is shown today, and included in the federal government's consolidated totals. Because the health alliances are expected to balance their income and outgo, including them in the totals would have no significant effect on the deficit. But the alliances' payments to health plans would swell federal outlays, and mandatory payments of health insurance premiums by firms and individuals would add to federal receipts.

Maintaining a separate accounting for the health alliances would not stand in the way of obtaining a complete picture of the impact of the federal sector on the economy. The consolidated totals would reveal "the full scope of the programs and transactions that are within the federal sector and not subject to the economic disciplines of the marketplace," as the President's Commission on Budget Concepts recommended, and would allow policymakers and the public to evaluate the Administration's proposal in a comprehensive fashion. But keeping the health alliances separate would make clearer the many complex interactions among the proposal's components and would recognize and accommodate the proposal's unique aspects, which prevent it from fitting neatly into any existing budgetary pigeonhole.

Table 3-1.
Suggested Budgetary Display of the Administration's Health Proposal, Fiscal Year 2004 (In billions of dollars)

	Outlays	Receipts	Surplus or Deficit (-)
CBO Baseline			
On-Budget	2,007	1,503	-503
Off-Budget			
Social Security	412	550	138
Postal Service	0	0	0
Consolidated Total	2,419	2,054	-365
Effect of the Proposal			
On-Budget	52	44	-7
Off-Budget			
Social Security	2	9	8
Postal Service	0	0	0
Health alliances[a]	513	513	0
Consolidated Total	566	566	b
Baseline with the Proposal			
On-Budget	2,058	1,548	-510
Off-Budget			
Social Security	414	559	146
Postal Service	0	0	0
Health alliances[a]	513	513	0
Consolidated Total	2,985	2,620	-365

SOURCE: Congressional Budget Office.

a. Receipts of the health alliances would comprise premiums from employers and households and payments by state governments. Federal transactions with the health alliances would be treated as intragovernmental outlays.

b. Less than $500 million

Conclusion

Two aspects of the Administration's health proposal have made its budgetary treatment particularly contentious. First, the proposal is innovative and complex, and existing budgetary concepts and precedents are less helpful than usual. Second, the proposal does not spell out the requirements for financial reporting by the federal government or the fiscal rules controlling the system of regional and corporate health alliances.

For these reasons, the Congress will want to consider carefully the budgetary presentation and control of the health alliances in its deliberations on the Administration's proposal. If the Congress decided to include the income and outgo of the alliances in the federal government's accounts, it could facilitate their recording and control by requiring them to flow through the Treasury. In any event, the Congress should require the federal government to provide regular financial reports on the health alliances and should bring the alliances under some form of fiscal discipline to ensure that existing budgetary rules are not circumvented.

Chapter Four

Economic Effects of the Proposal

Any fundamental reform of the health care system could have profound effects on the structure of the U.S. economy, and the Administration's proposal is no exception.

Supporters of the Administration's approach argue that it would improve the efficiency of labor markets by reducing insurance-related job lock and the work disincentives Medicaid beneficiaries face. They claim that it would also improve the allocation of resources in the economy by increasing the efficiency of the health sector and strengthen the competitive position of U.S. producers, particularly those with large health burdens for retired workers. Critics of the proposal have argued that it would raise business costs, devastate small enterprises, put some low-wage workers out of their jobs, encourage many workers to leave the labor force, and adversely affect the competitive position of U.S. industry.

This chapter examines the probable impact of the Administration's proposal on important aspects of the economy--business costs, employment, labor markets, and international competitiveness. The complexity of the proposal and of the current U.S. health insurance system makes analyzing these topics especially difficult, and few conclusions can be reached with great precision.

Several conclusions can, however, be drawn with relative confidence. First, the proposal would increase the cash wages of U.S. workers (see Chapter 2). Second, the proposal would without doubt involve a substantial redistribution of costs within the economy, and thus would have important consequences for individual workers and firms. Third, some low-wage workers would lose their jobs because their employers would have to pay for insurance, but this group is likely to be quite small; some others may gain jobs in community-based care for the disabled. Finally, more workers would voluntarily leave employment in response to new incentives created by the proposal, and some workers would enter employment for this reason.

Although the complexity of the proposal makes quantitative inferences imprecise, the Congressional Budget Office estimates that the plan might reduce the number of people in the labor force by one-quarter of a percent to 1 percent, though it would alter the unemployment rate little. Perhaps more important than its effect on the overall labor supply, the proposal is likely to affect the current pattern of where people work.

The Administration's proposal would affect labor markets both by eliminating or reducing existing distortions in these markets and by introducing new ones. Among the distortions that would be reduced are the tendency of the current system to lock people into certain jobs or into welfare because they fear the loss of insurance. It would also end the advantages big firms have in purchasing health insurance. These are important gains. But the proposal would also introduce some distortions of its own: it would encourage early retirement; it would in some cases reduce the attraction of having more than one adult in each family work; it would increase the cost of hiring most minimum-wage workers; and it would encourage the grouping of workers in firms on income lines that may not be efficient.

On balance, the new distortions in the labor markets could outweigh the ones eliminated; should that happen, the productive potential of the econ-

omy would go down, and fewer people would be engaged in market vities that produce income. But the potential loss of mark.. income would overstate any loss to the economy. People who leave work would be doing so from choice and would be able to do things they could not do while working. Although the value of this leisure is certainly not zero, it is not counted in gross domestic product.

A full accounting of the proposal's effect on the economy would have to include its possible impact on the efficiency of the health care system. Few analysts doubt that the current health care system wastes resources (see Box 4-1). The proposal hopes to reduce many of these inefficiencies. The Administration aims to cut administrative costs, foster the growth of health maintenance organizations and other types of plans that might be able to reduce costs below those of fee-for-service providers, and make it easier for consumers to pick more cost-effective health plans. For the most part, this report does not address these questions of the efficiency of the health sector.

Finally, any proposal to reform the current health care system would introduce its own distortions while eliminating others. Evaluation of the Administration's proposal should, therefore, be based on how its costs and benefits compare with those of the alternatives--including current policy

Box 4-1.
Inefficiencies in the Current Health Care System

For many economists and policymakers, the large proportion of national income going to the health sector--some 14 percent of gross domestic product in 1993--is cause for considerable concern. Behind this concern is a belief that health care markets as currently structured are not efficient and are prone to excessive and unnecessary spending.[1] A successful restructuring of the health care system would correct some of these inefficiencies.

Several factors now hinder the efficient operation of the health sector. First, consumers lack key information about the quality and price of medical services. Treatment costs are difficult to obtain in advance, and comparison shopping can be costly and impractical for sick people. Patients delegate a considerable amount of decisionmaking to their doctors, who are trained to provide the best possible care rather than the most cost-effective care.

Second, the widespread prevalence of health insurance (and other third-party payers) insulates consumers from the full cost of medical care when they are sick. Moreover, health insurance is tax deductible when employers offer it as a fringe benefit, which reduces the incentive for workers to select less expensive policies. Because employers pick up most of the bill, most employees have little idea how much their insurance truly costs.

Because of these shortcomings, health care markets are not truly competitive. Providers generally do not compete as aggressively over price as in other sectors of the economy. Instead, their competition focuses on the nonprice aspects of medical care. For example, hospitals try to attract patients by offering the best and latest medical technologies or the most comfortable surroundings--not the lowest price. At the same time, consumers lack sufficient bargaining clout to offset the tendency of the system to spend too much. The payment system is relatively fragmented, and providers are able to shift costs from large organized payers (like government) to private payers with little countervailing power.

Perhaps most important, technological change is very rapid in the health care sector, but market constraints that might ensure that new technologies are used in cost-efficient ways may not operate effectively. As long as health insurance pays for new technologies, the private sector is encouraged to develop any innovation, regardless of cost, that is likely to improve the quality of care. Other countries strictly control the supply of new technology to the health sector. But there is no effective mechanism in the current U.S. system--neither a market nor a government regulatory plan--to ensure that the costs of new technologies will be kept in line with their benefits.

1. Congressional Budget Office, *Economic Implications of Rising Health Care Costs* (October 1992).

Key Aspects of the Proposal That Would Affect the Economy

The Administration's proposal contains literally hundreds of provisions that would make fundamental changes in the delivery and financing of the nation's health care. Nevertheless, the most important economic effects can be traced to just a few features

Universal Coverage

The Administration's proposal would entitle all citizens and certain other people residing in the United States to a standard package of health insurance benefits. Unlike the current system, benefits would no longer depend on whether or where a person worked

Community Rating

Insurance premiums could not vary with age or health status. The new system would therefore incorporate the cost and spread the burden for people who present the greatest health risks.

Controls on Health Insurance Premiums

The Administration's proposal would limit the growth of health spending by fostering competition and capping premium costs.

Employers' Responsibilities

Employers would be required to pay a significant share of the health insurance premiums for virtually all of their employees. Health benefits would no longer be a flexible component of employee compensation but rather would become an inflexible levy on employing workers.

Subsidies to Employers

A firm in a regional alliance would not have to pay more than 7.9 percent of its wage and salary payroll for its share of health insurance; instead, the government would pay for premiums for the standard insurance package above that amount. Lower limits would apply to firms with 75 or fewer employees and low average wages.

Subsidies to Early Retirees

The government would subsidize the average premium for early retirees. This would reduce the incentive to continue to work, thus changing the size of the work force.

The Effects on Health Spending by Business

The Administration's proposal would maintain the central role of employers in financing health care in the United States, but would significantly alter the distribution of costs among businesses and workers After 1996, the proposal would most likely reduce the total spending of business on health care. Of course, businesses would be asked to pay directly for insurance for those workers who are currently uninsured, and the Administration's proposed insurance package is more generous than many firms currently offer. Employers who formed corporate alliances would pay an additional 1 percent payroll tax. But although these factors would tend to increase businesses' costs, they would be more than offset after 1996 by the limits on premium growth and the subsidies from the government.

Big Cost Reductions Overall for Business

When all these factors are taken into account, the total cost that all businesses together would pay for health insurance for active workers would be about $20 billion less in the year 2000 if the proposal were implemented than if the current system were

to continue unchanged.[1] The estimated reduction in the cost for active workers from the proposal would be even larger in subsequent years, reaching slightly above $90 billion in 2004.

Businesses would also benefit from a large reduction in costs for workers taking early retirement. This reduction would amount to more than $15 billion in the year 2004, and more thereafter.

Diverse Effects Among Individual Firms

Even though the plan would quite dramatically reduce the overall cost of health insurance for business, it would have widely differing effects on individual firms and industries, in some cases causing costs to rise and in others reducing them. Three factors account for most of the diversity.

Requiring All Employers to Pay. The requirement on all employers to contribute would raise spending by firms that do not currently offer insurance--or that offer a less generous insurance package--to their workers. These firms are disproportionately small--in 1989, over 94 percent of firms with 25 or more employees offered health insurance, but only 39 percent of firms with fewer than 25 employees did so.[2]

Community Rating. Currently, the cost of health insurance varies tremendously among firms, depending on the size of the firm and the age and health status of its workers. Under the Administration's proposal, insurance premiums would be community rated, which would greatly reduce this variation in health spending. For example, community rating would increase the costs of firms that employ younger and healthier workers and those in low-risk jobs, and decrease the costs of firms employing older and sicker workers and those in risky jobs. Further, community rating would benefit smaller firms that typically pay much higher premiums than larger firms. This leveling of costs could benefit all small businesses--not just those that provide insurance today. With access to more affordable insurance, small businesses would be better able to attract workers who now demand health insurance as a condition of employment.

Estimating the effect of these two factors--community rating and requiring all firms to pay--on various industries is beyond the scope of this study, but estimates prepared by Henry Aaron and Barry Bosworth at the Brookings Institution provide a rough guide (see Table 4-1).[3] These calculations do not capture some key aspects of the Administration's proposal. For example, they do not include the effects of subsidies to firms, nor do they allow for variations in the premiums among regional alliances that would occur under the proposal. Most important, they do not include the cost savings that controls on premiums would bring about.

Nevertheless, Aaron and Bosworth's estimates suggest that community rating and requiring firms to pay would cause an enormous redistribution of resources among workers in different industries. The redistribution would be even greater among subsectors of industries and individual firms not shown in the table. For example, Aaron and Bosworth's detailed estimates suggest that these two factors would decrease the annual cost of health insurance by almost $6,000 per worker in the coal mining industry--but increase it by $1,300 in the retail sector.

These redistributions are not unique to the Administration's proposal. Most proposals to reform the nation's health care system involve some community rating, and some also require all employers to pay. Those proposals would also redistribute large amounts of resources among firms and workers.

Subsidies to Firms. The subsidies to employers in the Administration's proposal would also affect how

1. The Administration also predicts that the plan would reduce business spending, compared with current policy, by similar amounts. By contrast, another analysis, by the consulting firm Lewin-VHI, estimated that the proposal would increase business spending by about $16 billion in 2000. See Lewin-VHI, *The Financial Impact of the Health Security Act* (Fairfax, Va.: Lewin-VHI, December 1993).

2. Congressional Budget Office, *Rising Health Care Costs: Causes, Implications, and Strategies* (April 1991).

3. The premiums under community rating in Table 4-1 are not identical among industries because each industry pays a different amount for retirees.

Table 4-1.
Effects of Community Rating and Requiring Firms to Pay on the Health Insurance Costs of Private Employers, by Industry, 1992

Industry	Employer Contributions for Health Insurance: Current Costs: Dollars per Worker[a]	Current Costs: Percentage of Wages	Costs with Community Rating and All Firms Paying (Dollars per worker)[a, b]	Difference: Dollars per Worker[a, b]	Difference: Percentage of Wages
Agriculture, Forestries, and Fishing	394	2.5	2,041	1,647	10.3
Mining	4,776	11.4	3,048	-1,728	-4.1
Construction	1,572	5.4	2,373	800	2.7
Manufacturing	3,466	10.7	2,416	-1,050	-3.2
Durable goods	3,801	11.2	2,452	-1,349	-4.0
Nondurable goods	3,017	10.0	2,367	-649	-2.2
Transportation	2,221	7.1	2,412	191	0.6
Communications	6,572	15.6	3,070	-3,502	-8.3
Electric, Gas, and Sanitary Services	4,871	11.3	2,804	-2,067	-4.8
Wholesale Trade	2,426	7.1	2,177	-249	-0.7
Retail Trade	788	4.5	2,090	1,303	7.5
Finance, Insurance, and Real Estate	2,123	5.9	2,190	67	0.2
Services	1,480	5.5	2,177	697	2.6
Private Households	0	0	2,041	2,041	16.5
All Industries	2,017	7.2	2,253	236	0.8

SOURCE: Congressional Budget Office based on Henry Aaron and Barry Bosworth, "Economic Issues in the Reform of Health Care Financing," *Brookings Papers on Economic Activity* (forthcoming).

a. Based on full-time-equivalent workers.

b. Includes a 13 percent increase in average costs to cover uninsured workers and assumes uniform costs for nonretirees (community rating). Does not reflect the effects of the cost controls in the Administration's proposal. Retiree health costs account for the variation among industries.

insurance costs are distributed among companies. Other things being equal, firms with low wages would be more likely to be subsidized. Many small firms would also face lower caps (and receive larger subsidies per person) than large firms. Finally, firms located in regions of the country with high medical costs might receive higher subsidies because their premiums would be higher. Yet some regions with high medical costs also pay higher wages, so it is difficult to infer the regional impact of the Administration's proposal without more information about how the boundaries of the alliances would be drawn.

Who Bears the Burden of Health Spending by Business?

Although businesses initially pay a large portion of the bill for health insurance, 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 for the most part, the nation's workers shoulder the cost of employers' premiums for health insurance. Thus, the signifi-

cant savings that the Administration's proposal would produce compared with current policy would be largely passed on to workers in the form of higher wages.

Why Workers Pay for Health Costs

The primary reason that workers as a group bear the cost of employers' health premiums--and would realize the savings under the Administration's proposal--is that the supply of labor is relatively insensitive to changes in take-home wages. Recent empirical studies suggest that the total hours supplied by U.S. workers would decline only 0.1 percent to 0.2 percent for each 1 percent reduction in their take-home wage.[4] Because most workers continue to work even if their take-home pay declines, businesses have little trouble shifting most of the cost of health insurance to workers' real wages. Similarly, workers gain the lion's share of any reductions in employers' health costs.

Two recent studies of mandated benefits mirror this view.[5] In one study, firms shifted 85 percent of the cost of mandated "workers' compensation" accident insurance to workers in the form of lower real wages; another study found that virtually all of the cost of federal and state mandates for childbirth coverage was passed into lower real wages.[6]

Of course, because labor supply is not completely insensitive to changes in wage rates, shareholders would bear some of the changes in health insurance costs in the short run. But they would probably bear virtually none of these costs in the long run. The United States operates in a world economy and, if businesses attempted to shift such costs to capital, shareholders would move their investments to other countries that offered them higher returns.

Shareholders, however, would benefit from reductions in the cost of retirees' health insurance. The Administration's proposal would reduce costs for companies that currently have large retiree health obligations. The government would take over a significant portion of companies' responsibility for health insurance for early retirees and drugs for older retirees. The companies' workers and their unions would probably fight for a portion of that windfall, and the gain would therefore be split among shareholders, workers, and retirees.

How Savings Might Be Distributed

Although the wages of workers (as a group) would increase to reflect reductions in the cost of health insurance for current employees under the Administration's proposal, the benefits would not be spread evenly among individual workers for at least two reasons.[7] First, by evening out the costs of insurance, community rating would raise the costs of employing some individuals relative to current policy, but reduce them for others. Second, individual firms could respond differently to these changes in costs. Some might change the nominal wages of their workers; others might adjust their prices.

For the economy as a whole, lower prices for some products would largely be offset by higher prices for others.[8] But because individuals purchase

4. Congressional Budget Office, "Taxes and Labor Supply," CBO Memorandum (forthcoming); Mark Killingsworth, *Labor Supply* (Cambridge, England: Cambridge University Press, 1983); and James Heckman, "What Has Been Learned About Labor Supply in the Past Twenty Years?" *American Economic Review*, vol. 83, no. 2 (May 1993), pp. 116-121.

5. Jonathan Gruber and Alan B. Krueger, "The Incidence of Mandated Employer-Provided Insurance: Lessons from Workers' Compensation Insurance," *Tax Policy and the Economy* (1991); and Jonathan Gruber, "The Incidence of Mandated Maternity Benefits," *American Economic Review* (forthcoming).

6. Lawrence H. Summers, "Some Simple Economics of Mandated Benefits," *American Economic Review*, vol. 79, no. 2 (May 1989), pp. 177-183. The Administration's proposal would probably have a smaller effect on real wages--and a larger effect on employment--than implied by these studies. Unlike a pure employer mandate, the Administration's proposal would entitle everyone to insurance whether they worked or not and would finance the proposal through a compulsory payment.

7. Henry Aaron and Barry Bosworth, "Economic Issues in the Reform of Health Care Financing," *Brookings Papers on Economic Activity* (forthcoming).

8. Because the Administration's proposal would cause the labor force and output of the economy to fall slightly, the overall price level could rise somewhat in the long run compared with current policy. The effect on output and prices would be somewhat larger in the short run because firms that would face cost increases might not be able to reduce the nominal wages of their workers. Over time these firms would be able to bring nominal wages back in line by simply not compensating their workers for general inflation. Finally, this discussion excludes any possible actions by the Federal Reserve.

different bundles of goods and services, individual workers and consumers could experience significantly different effects.

In some respects, the Administration's proposal would reduce the likelihood that firms with cost increases would raise prices. Community rating virtually assures that competing firms would face very different changes in their insurance costs. Unless most competitors in an industry faced similar changes in their costs, it would be difficult for any single firm to raise its prices much without losing market share.

What Would Happen to the Labor Force and Unemployment?

The Administration's health proposal would sharply change the terms of the employment bargain for many workers, reducing some distortions implicit in the current system and imposing others. Overall, the proposal would probably impose greater employment-related distortions than it removed. The supply of labor would probably fall slightly, somewhat reducing the productive capacity of the economy, but unemployment would be little changed.

In summary, the proposal would:

- Encourage workers nearing retirement age to retire early, by subsidizing their health insurance in early retirement;
- Reduce the value of working for people who receive insurance through their spouses and currently work at firms without insurance;
- Reduce the current incentive for recipients of Aid to Families with Dependent Children to remain on the welfare rolls and out of work in order to maintain their Medicaid benefits; and
- Raise the cost of hiring some adult workers who earn close to the minimum wage, thus slightly reducing their employment.

These direct effects of the plan--which would result on balance in a reduction in labor supply--would in turn produce a partially offsetting change. Competition among employers for the reduced labor supply would slightly raise real wage rates. But the effect of a rise in wages would not completely offset the direct effects of the proposal.

Increase Early Retirement

Three features of the Administration's proposal would create significant incentives for workers between 55 and 64 years old to take early retirement. First, because the proposal would guarantee universal coverage and premiums would not vary with health or employment status, early retirees need not fear becoming uninsured. Thus, older people would no longer have to work simply because they need access to affordable health insurance. Most analysts would regard this as a clear improvement over the current situation, even though it would reduce the supply of labor.

Second, the proposal goes further and would subsidize health insurance for retired people between the ages of 55 and 64. However, people in this age group who worked full-time (or whose spouses worked full time) would not receive this benefit. The subsidies would sharply reduce costs for those firms that currently offer health insurance to early retirees, and might induce them to sweeten the other components of their retirement package.[9] Aside from any consideration of fairness, this provision would clearly reduce the incentive to work.

Finally, community rating among age groups means that early retirees would face premiums that, even before considering subsidies, would be no higher than those paid by younger people. Because older people currently pay much higher premiums than young people, community rating would significantly reduce the savings that workers would need to accumulate for retirement, and some might find they could retire earlier.

9 Roughly half of the savings for these firms in 1998 through 2000 would be recaptured by the government. The proposal includes no provisions to recapture savings from firms after 2000

The Administration estimates that the health proposal could increase the number of retired workers ages 55 to 64 by 350,000 to 600,000. CBO's analysis also suggests effects in about this range, although probably closer to the upper end or slightly above. These estimates are roughly consistent with the results of a recent study by Brigitte Madrian of Harvard University.[10]

Impose an Implicit Levy on Work

The Administration's proposal would bring about a major change in the nature of health care costs: for many workers, the cost would operate like a new levy on work. However, most people's decisions about whether to work or not are not particularly sensitive to changes in their take-home wages or salaries. Consequently, the effect of the proposal on the total labor force would be relatively small and limited largely to second workers in households in which one person already works.

The proposal would create an implicit levy on work because it would make health coverage universal without charging many nonworkers for the full cost of their insurance. In other words, coverage under the proposal would not depend on whether one worked and paid the premium or stayed at home and, often, paid much less. The premium would simply reduce take-home pay without, from the point of view of the individual worker, buying anything.

By contrast, under the current system, employers provide health insurance to many of their workers as part of an implicit or explicit bargain, which ensures that the cost of health insurance does not stray too far from what most workers feel it is worth.[11] Thus, health insurance is a component of compensation that substitutes for cash wages and, therefore, has little effect on an individual's decisions about whether and how much to work.

That bargain is not perfect for several reasons. Most important, some married people who work in firms that offer health insurance are or could be covered under a spouse's policy.[12] For these people, the availability of health insurance at work is worth little. But many of these workers are not compensated in other ways for the insurance they do not use.[13] This situation distorts decisions about whether and where to work; it also partly explains why some married women work in firms that do not offer insurance.[14]

The Administration's proposal would extend this distorting effect on decisions about work to everyone. However, the proposal would also reduce premiums for currently insured workers because all workers would have to pay for insurance and because administrative costs are apt to be less--particularly for small firms. On balance, the proposal would probably impose a somewhat larger distortion on decisions about work than exists under the current system.

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10. Brigitte Madrian, "Labor Market Effects of Employment-Based Health Insurance" (Ph.D dissertation, Massachusetts Institute of Technology, Cambridge, 1993), Chapter 2. Other studies suggest much larger responses. See Jonathan Gruber and Brigitte Madrian, "Health Insurance Availability and the Retirement Decision," Working Paper 4469 (National Bureau of Economic Research, Cambridge, Mass., September 1993); and Michael Hurd and Kathleen McGarry, "The Relationship Between Job Characteristics and Retirement," Working Paper 4558 (National Bureau of Economic Research, Cambridge, Mass., December 1993). Although one study found that retirees' health insurance had little effect on retirement, those results cannot be applied to the Administration's proposal; see Alan Gustman and Thomas Steinmeier, "Employer-Provided Health Insurance and Retirement Behavior," Working Paper 4307 (National Bureau of Economic Research, Cambridge, Mass., March 1993).

11. Employer-paid health insurance premiums are not included in a worker's taxable income for either income tax or payroll tax calculations. Thus, health insurance benefits that have a lower value than a given amount of cash wages before taxes may have a higher value after taxes are accounted for. The statement in the text refers to workers' after-tax valuation of insurance benefits.

12. Another reason that the employment bargain is not perfect is that some health care is available to people without insurance. Workers who pay for insurance effectively subsidize these "free riders."

13. At the few firms that offer "cafeteria" plans, workers can substitute wages or other benefits for unneeded health insurance. Similar adjustments may also occur at other firms, but it is hard to know whether this phenomenon is widespread. If such adjustments are widespread, then fewer people would be in the category described in the text.

14. Patricia M. Danzon, "Mandated Employment-Based Health Insurance: Incidence and Efficiency Effects," Working Paper 60 (Center for the Study of the Economy and the State, University of Chicago, Chicago, Ill., April 1990).

Would everyone recognize that the proposal imposed a distortion? Perhaps not. Some workers may not recognize the implicit trade-off in the current system between employer-paid health insurance benefits and cash wages.[15] For these workers, the Administration's proposal would not appear to represent such a fundamental change in the employment bargain.

Although the proposal would reduce the incentive to work for many workers, the vast majority would nevertheless remain in the labor market because they need wage and salary income to support themselves or their families. But some people—especially those whose spouse is employed—have more flexibility in their decision to work. These so-called "secondary" workers are more responsive to changes in work incentives because they can rely on their spouse's income. The Administration's proposal would thus reduce the participation of secondary workers in the labor force.

Encourage Medicaid Beneficiaries to Enter the Labor Force

The Administration's proposal would reduce the current incentive for AFDC beneficiaries to remain on welfare. Under current rules, when a welfare beneficiary goes to work and earns income above certain thresholds, the beneficiary may lose both eligibility for cash assistance and Medicaid coverage.[16] Because such workers may not find employment at a firm that offers insurance, they may lose access to affordable health benefits if they work.

The Administration's proposal, by contrast, would make coverage universal. Thus, welfare beneficiaries would not risk losing coverage if they worked. Note, however, that these workers would not receive free insurance when they went to work. Like all other workers, they would ultimately pay for the employers' share of insurance through lower cash wages. Thus, the net incentive for welfare recipients to work would be less than it may at first appear.

Still, the proposal would subsidize health insurance at many firms, and workers at such firms would have to pay, at most, 7.9 percent of their wages for insurance (and less if the firm is small and has a predominantly low-wage work force). Premiums at unsubsidized firms could, however, absorb a substantial fraction of these workers' wages; few welfare recipients would probably seek jobs in the unsubsidized sector.

These workers could also receive some subsidies for the family share. If the worker continued to receive AFDC assistance, he or she would pay nothing. Workers who were no longer enrolled in AFDC would also receive subsidies, although they would be required to pay a portion of the family share.[17] These subsidies would phase out gradually as the worker's family income rose, reaching zero when income was 150 percent of the poverty level. The phaseout of the subsidy would impose an implicit levy on additional hours of work.

Empirical studies show that Medicaid has reduced participation in the labor force.[18] But estimating the effects of the Administration's proposal is difficult because the available studies cannot easily be adapted to it. Nevertheless, the literature suggests that the proposal would noticeably increase participation of AFDC recipients in the labor force.

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15. Aaron and Bosworth, "Economic Issues in the Reform of Health Care Financing."

16. Different thresholds apply for AFDC eligibility and Medicaid eligibility. Medicaid coverage may be maintained for a transition period of up to 12 months after starting work.

17. When a family no longer received AFDC, the family would also lose the subsidy for copayments and supplementary services for the parent. Supplementary services for children would be continued as at present.

18. Aaron Yelowitz, "The Medicaid Notch, Labor Supply, and Welfare Participation: Evidence from Eligibility Expansions" (Massachusetts Institute of Technology, Cambridge, September 1993); Sandra Decker, "The Effect of Medicaid on Participation in the AFDC Program: Evidence from the Initial Introduction of Medicaid," (New York University, New York, N.Y., 1993). Robert Moffitt and Barbara Wolfe, "The Effect of the Medicaid Program on Welfare Participation and Labor Supply," *The Review of Economics and Statistics*, vol. 74, no. 4 (November 1992), pp. 615-626. Anne E. Winkler, "The Incentive Effects of Medicaid on Women's Labor Supply," *The Journal of Human Resources*, vol. 26, no. 2 (Spring 1991), pp. 308-337. Rebecca M. Blank, "The Effect of Medical Need and Medicaid on AFDC Participation," *The Journal of Human Resources*, vol. 24, no. 1 (Winter 1989), pp. 54-87.

Redirect Employment of Low-Wage Workers

The Administration's health proposal would affect employment of low-wage workers in a variety of ways. It would raise labor costs at uninsured firms and would reduce the employment of some of their low-wage, adult workers. But it would also reduce labor costs at insured firms, which could tempt some of them to employ more workers. At the same time, the proposal would increase employment of workers who provide services for the disabled and could induce a shift toward teen and student employment. On balance, the Administration's proposal would probably have only a small effect on low-wage employment.

Workers at Firms Without Insurance. The Administration's proposal would reduce the employment of adult workers who are currently uninsured and whose wages are close to the federally regulated minimum wage. The requirement that firms pay for insurance would raise the cost of employing these workers, but because of the minimum wage rules, employers would not be able to pass the increased cost fully back to the workers by reducing their cash wages. Thus, firms that could not absorb these costs in profits or could not raise their prices might resort to layoffs.

The amount of the cost increase for minimum-wage workers would vary significantly from firm to firm.[19] Firms subject to the premium caps, and thus subsidized, would experience increases amounting to between 15 cents and 34 cents per hour--probably not enough to have a serious impact on employment. The increases at unsubsidized firms would be substantially larger, amounting to about $1 per hour (or close to 25 percent) for full-time workers choosing individual policies in 1998 and almost $2 per hour (nearly 45 percent) for workers choosing family policies.[20]

Some firms would respond to this cost increase by raising their prices; others might pass the increase on to other workers or shareholders. Some firms would reduce employment, but the effect would probably be relatively small. Past empirical studies suggest that changes in the minimum wage affect employment only modestly.[21] Moreover, the numbers of workers earning the minimum wage will decline over time as market wages rise with general inflation.

Workers at Insured Firms. Not all low-wage workers would face increases in health costs. Although most firms that employ minimum-wage workers do not offer insurance to those workers, some firms do, and these firms would most likely see their costs go down. A firm that is subject to the payroll cap would have to pay no more than $700 to cover the insurance cost of a full-time minimum-wage worker--considerably less if the firm is small and employs mostly low-wage workers--and this amount would be well below the cost of most current health plans. Because small, unsubsidized firms would benefit from community rating and from a reduction in administrative costs, many of them would also see their costs go down. In firms where costs could fall, employment of low-wage workers could rise, though again not by much.

Teenagers and Students. The Administration's proposal does not require employers to pay for employees who are dependents and who are either under age 18 or full-time students under age 24. Thus, the proposal would reduce the cost of hiring these workers relative to adult minimum-wage workers. This provision could induce a shift toward employment of teens and students and away from adult nonstudent workers, although it is difficult to estimate the magnitude of this effect.

19. For information on insurance coverage of low-wage workers, see Congressional Budget Office, "In Pursuit of Higher Wages and Employment-Based Health Insurance," CBO Memorandum (February 1993).

20. Using CBO's premium estimates for 1998 and assuming a 37-hour week for 52 weeks.

21. Allison Wellington, "Effects of the Minimum Wage on the Employment Status of Youths: An Update," *The Journal of Human Resources*, vol. 26, no. 1 (Winter 1991), pp. 27-46; "New Minimum Wage Research: A Symposium," *Industrial and Labor Relations Review*, vol. 46, no. 1 (October 1992), pp. 3-84; David Card, Lawrence Katz, and Alan Krueger, "An Evaluation of Recent Evidence on the Employment Effects of Minimum and Subminimum Wages," Working Paper 4528 (National Bureau of Economic Research, Cambridge, Mass., November 1993); Janet Currie and Bruce Fallick, "A Note on the New Minimum Wage Research," Working Paper 4348 (National Bureau of Economic Research, Cambridge, Mass., April 1993).

Personal Care Workers. The Administration's proposal would also directly increase employment in one low-wage area--personal care and other in-home workers. Although most aspects of it aim to reduce spending on health care, the proposal would substantially increase funds for home- and community-based care, which would expand the employment of both higher-paid and lower-paid workers in this sector.

The proposal also could bring into the labor force statistics--and into the gross domestic product accounts--an unknown number of family members who currently provide uncompensated care for the disabled. Current rules do not permit these people to be paid with government money, and thus they are not counted in the labor force or in GDP. The proposal would allow these people to be paid and thus bring them into both sets of statistics. The recognition of the work effort of these family members would be important to the disabled and their families. From the national point of view, however, this would be largely a statistical change and would not alter the true amount of economic activity.

What Would Happen to the Structure of the Labor Market?

The Administration's health proposal would create incentives for reorganizing the structure of production. To start, these incentives would alter the number of hours that people work, and particularly the decisions of firms to hire full-time or part-time workers. The proposal would also allow workers to switch jobs without losing insurance, but it might induce some reallocation of workers among firms in an effort to receive greater government subsidies.

Hours of Work

The Administration's proposal would affect not only the number of workers in the economy but also the number of hours that they work. Specifically, the proposal would encourage a reduction in hours for full-time workers in subsidized firms but an increase in hours for full-time workers at some unsubsidized firms. The proposal would also encourage a reduction in the hours of most part-time workers.

Subsidized Firms. Under the proposal, subsidized firms would pay an implicit levy on the wages earned by their employees from each additional hour of work. At many subsidized firms, this levy would equal 7.9 percent; at small firms with low average wages, it could be as low as 3.5 percent. The levy would apply to full-time and part-time workers in the same way, and would be passed back to workers in the form of lower wages. This provision would create an incentive for both full-time and part-time workers at subsidized firms to reduce their hours of work.

Unsubsidized Firms. At unsubsidized firms, the proposal would impose no added cost on the wages earned from additional hours of work by people already working more than 30 hours per week. Thus, at unsubsidized firms that offer insurance today, the proposal would have no appreciable effect on hours worked by full-time employees. At unsubsidized firms that do not offer insurance today, however, there would be a new fixed cost of hiring additional full-time workers, which would cause firms to use more overtime by their existing workers.

Part-time employees at unsubsidized firms would face an implicit levy on hours because the proposal prorates premiums for these workers. For an additional hour of work by employees working between 10 and 30 hours per week, unsubsidized firms would generally have to pay one-thirtieth of the basic employer premium. This amount could be large relative to the wages of some low-wage workers.[22]

Workers with Very Short Hours. The proposal might cause some firms to increase their use of employees who work fewer than 40 hours per month

22. The proposal would impose particularly large costs on part-time workers with jobs in more than one unsubsidized firm. For example, the combined employer premiums for a worker who has two 20-hour-a-week jobs are 33 percent more than the employer premium for a 40-hour worker with just one job. This situation does not exist for workers in subsidized firms because they pay a fixed percentage of their salary regardless of their hours of work.

because neither subsidized nor unsubsidized firms would be required to pay premiums for these workers. The number of such workers would probably be small, however, and they would primarily be workers with low training and transportation costs.

Effect on "Job Lock"

Some of the proposal's provisions would reduce problems created by the current employment-based system of health insurance. Under the current system, people may be reluctant to leave the safety of a large corporation to work in a small company or start a small business because they fear losing their health insurance. Because the proposal would establish universal coverage and prohibit restrictions based on preexisting health conditions, this fear would be lifted. Workers could choose jobs that gave them the most satisfaction and at which they had the highest productivity, thus improving economic efficiency.

The quantitative importance of job lock is unclear, however. Public opinion surveys suggest that 10 percent to 30 percent of people feel locked into their current jobs because of their fear of losing health insurance.[23] But statistical studies of the extent to which this fear actually reduces job mobility have reached mixed conclusions.[24] Overall, the weight of evidence suggests that job lock probably hinders the operation of the labor market to some degree, but the magnitude of the effect cannot be reliably estimated.

Reallocation of Workers Among Firms

The current system of employment-based health insurance influences the allocation of workers among firms. People who receive insurance coverage through their spouses—or low-wage workers who place a low value on health insurance relative to their other needs—have an incentive to work at firms that do not offer health insurance but pay higher wages instead. At the same time, higher-wage workers who do not have alternative access to insurance typically work at firms that provide insurance coverage.

The Administration's proposal would eliminate the allocation of labor based on workers' demand for insurance. But the proposal would substitute an incentive for reallocating labor (so-called "sorting") based on wages: to take advantage of the subsidies to firms available under the proposal, low-wage workers would migrate to firms with low average wages, and high-wage workers would eventually move to firms with high average wages. As with many other issues discussed in this chapter, the precise effects of the proposal would vary among workers and firms (see Box 4-2).

This sorting would occur because the subsidies are based on the characteristics of firms. Subsidies based purely on individual or family characteristics would not have this effect, nor would a payroll tax levied at uniform rates on all firms. Therefore, these incentives for sorting are somewhat particular to the financing mechanism in the Administration's proposal. Of course, alternative schemes for financing universal coverage could also introduce new distortions, though the precise effects would depend on the details of any alternative.[25]

The Incentive for Sorting A simple example illustrates how workers could benefit by moving between firms that were subsidized and firms that were unsubsidized. If an unsubsidized firm hired an additional single, childless worker at an annual salary of $10,000, its payments to the regional alliance

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23. Erik Eckholm, "Health Benefits Found to Deter Switches in Jobs," *The New York Times*, September 26, 1991, p. 1; Christopher Conte, "Labor Letter," *The Wall Street Journal*, June 15, 1993, p. A1.

24. Douglas Holtz-Eakin, "Job-Lock: An Impediment to Labor Mobility?" *Jerome Levy Economics Institute of Bard College Public Policy Brief*, vol. 10 (1993); Brigitte Madrian, "Employment-Based Health Insurance and Job Mobility: Is There Evidence of Job-Lock?" Working Paper 4476 (National Bureau of Economic Research, Cambridge, Mass., September 1993); Jonathan Gruber and Brigitte Madrian, "Limited Insurance Portability and Job Mobility: The Effects of Public Policy on Job-Lock," Working Paper 4479 (National Bureau of Economic Research, Cambridge, Mass., September 1993).

25. Louise Sheiner, "Mandates with Subsidies: Efficiency and Distributional Consequences" (Federal Reserve Board, January 1994).

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would rise by $2,031 (CBO's estimate of the employer share of the premium in 1998). By contrast, a subsidized firm would have to pay only $790 to the alliance if it hired the worker, since subsidized firms would pay only 7.9 percent of payroll for insurance. If the worker had the same value to both firms, the subsidized firm could pay a substantially higher annual salary—as much as $1,241 more—than the unsubsidized firm. This is a rather large difference; it would increase the worker's salary by more than 12 percent.

The incentive would work in the opposite direction for higher-wage workers, though it might take a long time to affect where people work. A single, childless worker earning an annual salary of $40,000 would have to give up $3,160 of his or her salary for insurance in the subsidized firm (7.9 percent of $40,000), and thus could save up to $1,129 each year by moving to an unsubsidized firm, where the premium would not be based on salary.

The size of the sorting incentive would vary among both workers and firms. In the example above, the incentive would obviously be amplified for workers with annual salaries above $40,000 or below $10,000. In addition, small firms with very low average wages would have capped rates as low as 3.5 percent, which would further boost the incentive for low-wage workers to work at these firms. Last, the size of the incentive would depend on the family status of the worker—workers with children would face higher premiums at unsubsidized firms than workers without children. At subsidized firms, the employer share of the premiums would simply be 7.9 percent of the worker's wages or salary whether the worker was a single adult, or part of a couple or a family with children.

Forms of Sorting. Sorting could take several forms, some involving actions of workers, some involving actions of firms, and some involving actions of both parties. For example, new workers in the labor force could choose jobs with certain firms rather than others. Or existing workers could quit and move to different firms.

Firms could "outsource"—that is, lay off employees and contract with other companies for the

Box 4-2.
Sorting of Workers in the Administration's Proposal

The incentive for sorting under the Administration's proposal would vary among workers, but most workers can be classified into one of three groups for this purpose.

First, the Administration's proposal would provide a substantial new incentive for sorting among workers who place a significant value on insurance and whose wages are flexible in the long run. Because these workers' wages adjust to reflect the cost of their employment-based health insurance, these workers face no incentive under the current system to leave their jobs. But under the proposed system, those who have low wages would seek jobs at subsidized firms, while those with high wages would seek out unsubsidized firms. This group is rather large—it includes all heads of households except those with very low incomes.

The second group of workers are those who place a high value on insurance but whose wages are not flexible even in the long run. Because the productivity of these workers may not be high enough to cover the minimum wage plus the cost of health insurance, they tend to find work at firms that do not offer insurance. If the current system is maintained, more of these workers would be forced into uninsured firms as the cost of health insurance rose. By contrast, the subsidies in the Administration's proposal would reduce this incentive for sorting. This group is not large and consists primarily of minimum-wage and near-minimum-wage workers.

The last group consists of workers who place a low value on insurance. The current system encourages these workers to work at firms without insurance, and again this incentive increases as health insurance costs rise. The Administration's proposal would eliminate this incentive for sorting because every firm would have to offer insurance. But the proposal would substitute an incentive for high-wage workers in this group to move to firms with high average wages and low-wage workers to move to firms with low average wages. This group is fairly sizable because it includes most secondary workers and some younger and poorer primary workers as well.

same services. For example, a firm with high average wages, which would be unsubsidized under the proposal, could give up its company's cleaning help and hire an outside cleaning service instead. Alternatively, firms could divide themselves into subsidiaries with low and high average wages. For example, a manufacturing plant could spin off its research and development lab.

Although the proposal contains legal restrictions on some of this sorting, they would not be totally successful.[26] The proposal would increase the Internal Revenue Service's authority over the classification of employees and independent contractors, but reclassification of these workers is just one of several ways in which firms could respond to the proposal. Moreover, any simple regulation is unlikely to prevent the creation of new firms that could use the subsidies to their competitive advantage against existing, regulated firms.

Sorting Would Raise the Cost of Federal Subsidies to Firms. When sorting occurs, workers would be reallocated among firms in a way that reduced the private cost of their health insurance. But this reduction in private cost would be exactly offset by an increase in government spending.

Of course, it is difficult to determine exactly how much sorting would occur under the Administration's proposal. Some restructuring along salary lines may be occurring anyway.[27] There are no empirical estimates indicating the sensitivity of the allocation of workers to incentives of this type. But the incentive for sorting under the proposal would be fairly large for many people. CBO estimates that in 1998 almost 8 million low-wage workers could receive salary increases of 10 percent or more by moving from unsubsidized to subsidized firms. And the average increase in salary for workers earning less than $20,000 who migrated from unsubsidized to subsidized firms would be over 15 percent.

CBO assumes that 20 percent of the workers would eventually respond to a potential 10 percent increase in their after-tax salaries; workers facing larger or smaller incentives would have proportionally larger or smaller responses. This sorting would not occur immediately, however. CBO assumes that it would take 10 years after full implementation of the proposal for sorting to reach its full extent and estimates that sorting could increase the cost of subsidies to firms by some $12 billion (or 14 percent) in 2004, an amount incorporated in the cost estimate in Chapter 2.

Sorting Would Alter the Effects of the Proposal on Employment. As discussed in an earlier section, the requirement that firms pay for health insurance would reduce the employment of low-wage workers. The sorting of these workers among firms would mute this effect, however. Low-wage workers who are currently uninsured would be induced to leave unsubsidized firms where they would face large implicit increases in the minimum wage and move to subsidized firms where the implicit minimum wage increase would be relatively modest. This migration would limit the number of displaced workers.

At the same time, sorting could produce some temporary loss of employment, if workers lost their jobs and were forced to look for new ones. Ironically, the harder the government tried to prevent sorting in the form of simple legal reorganizations, the more it would encourage firms to sort workers by laying them off. Of course, employers would be trying to contract with other companies to provide the same services, so overall demand in the economy for these workers' skills might be unaffected. But this possibility does not mean that the same workers would find jobs immediately, and those that could not would experience some short-run unemployment.

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26. Eugene Steuerle, "The Proposed Segregation of the Labor Market by Economic Class," *Tax Notes*, vol. 61, no. 5 (November 1, 1993), pp. 621-622.

27. Because some sorting would occur without any policy change, the subsidies to firms would grow over time even if the Administration's proposal induces no additional sorting. In other words, what matters for the cost of subsidies is the total amount of income-based sorting, not just the amount created by the proposal. See Katharine G. Abraham, "Restructuring the Employment Relationship: The Growth of Market-Mediated Work Arrangements," in Katharine G. Abraham and Robert B. McKersie, eds., *New Developments in the Labor Market* (Cambridge, Mass.: MIT Press, 1990); Katharine G. Abraham and Susan K. Taylor, "Firms' Use of Outside Contractors: Theory and Evidence," Working Paper 4468 (National Bureau of Economic Research, Cambridge, Mass., September 1993); and Steve J. Davis and John Haltiwanger, "Wage Dispersion Between and Within U.S. Manufacturing Plants, 1963-1986," Working Paper 3722 (National Bureau of Economic Research, Cambridge, Mass., March 1991).

Sorting Could Reduce the Efficiency of the Labor Market. A competitive market economy allocates workers to jobs where their productivity is highest. The current health insurance system distorts that allocation in at least two ways. First, it provides an incentive for workers who place a low value on health insurance received through their jobs to work for firms that do not offer insurance. Second, it raises the cost of labor at firms for which health insurance is more expensive. These distortions lower the efficiency of the labor market and the economy.

The Administration's proposal would eliminate these distortions, but would create a distortion of a different type, in which workers at different wage levels would have an incentive to work for different firms. By contrast, the current system creates no incentive to separate high- and low-skill workers into different firms. And most firms currently include both low-wage and high-wage employees, suggesting that heterogeneous wage (and skill) structures at firms may be more efficient than the homogeneous structures encouraged by the proposal. This efficiency may depend partly on the nature of production processes, which often involve people of different types and levels of skill. It may also depend on the difficulty of conducting transactions through explicit contracts with independent firms rather than informal arrangements within a single firm.

If grouping workers among firms by income or skill level is very inefficient, then the allocation of workers encouraged by the proposal might be less efficient than the current allocation. Also, the process of sorting--of reallocating workers--would entail administrative and organizational costs that would reduce efficiency. But if the efficiency cost of sorting were high, then the speed and ultimate amount of sorting would be relatively low.

What Would Happen to the International Competitive Position of the United States?

When the government makes policy changes as far reaching as the Administration now proposes, one of the biggest concerns of many businesses is how the changes might affect their international competitiveness. CBO's analysis concludes that because the proposal would affect different firms in different ways, some firms would become more competitive and some firms less so. But no solid conclusions can be drawn about whether the overall trade balance would increase or decrease.

Overall Competitiveness: The Balance of Trade

The notion of the "international competitiveness" of the whole economy is hard to define, but what most people mean by it, in practical terms, is a concern that the United States may lose exports or absorb more imports. Working by analogy with an individual firm, it is commonly believed that anything that increases costs would make the balance of trade worse, and anything that decreases costs would improve it. Almost all economists disagree with this view, however, because it neglects some important connections that exist in an entire economy but do not apply to an individual firm.

At a fundamental level, the trade balance of any country is constrained because a country, unlike a firm, can sell abroad only that part of its production that it does not consume or invest itself. Hence, the net amount of sales abroad--the balance of trade--depends most directly, not on costs of production, but on saving and investment.[28] The trade balance improves only if national saving rises, investment falls, or both.

The Administration's health proposal would have indeterminate effects on both national saving and investment. Thus, it is difficult to predict how the proposal would affect the balance of trade.

National Saving. According to CBO's estimates in Chapter 2, the Administration's proposal would marginally raise the federal budget deficit for most of the next decade, though ultimately it would decrease it. A decrease in the federal deficit corresponds to an increase in national saving.

28. Congressional Budget Office, *Policies for Reducing the Current Account Deficit* (August 1989).

The proposal could also affect private saving through several channels. First, universal health insurance would reduce some of the need of individuals to save for precautionary reasons. Precautionary saving arises when individuals are uncertain about, for example, their future income prospects, their life span, or the amount of money they may need to spend on medical services. In the case of medical needs, the amount of precautionary saving would depend on the probability of incurring outlays, the amount of outlays likely to be incurred, and the cost of insurance. It would also depend on income, wealth, and attitudes toward uncertainty. Because the proposal would eliminate the risk of losing insurance and facing large, unexpected medical expenses, it would probably reduce precautionary saving.[29] Of course, the reduction in risk would itself improve people's well-being. Second, some people between the ages of 55 and 64 might save less if the proposal encouraged them to retire earlier. This group, if they continued working, would normally have relatively high saving rates.

At the same time, two factors would work to increase private saving. First, some workers might want to save more during their working years if the proposal encouraged them to retire early. Second, the plan might reduce some people's incentive to spend down their assets if they expected to need Medicaid when they were older. The proposal would allow states to raise the maximum level of assets that single people on Medicaid could keep, thus slightly increasing the incentive to save. Overall, the proposal might reduce national saving somewhat.

Investment It is even more difficult to predict the effect of the proposal on investment. Because reallocating the burden of health care costs would affect industries very differently, some would increase investment and some decrease it. On net, because it is hard to shift plant and equipment from one firm or industry to another as one contracts and the other expands, such shifts could increase national spending on investment while adjustments occurred. But the effect would be very small: industries are always growing and declining, and the additional shifts as a result of reallocation of health care costs would be difficult to discern. Other factors—especially changes in the health care industry itself—could also affect investment, but it is impossible to predict whether they would cause investment to go up or down. On balance, the effect of the Administration's proposal on investment is uncertain.

The Competitiveness of Different Firms

Under the Administration's proposal, the health care costs of firms that compete directly with foreign firms (the "tradable goods sector") would probably decline. Those firms are much more likely than firms outside that sector to offer health benefits now, and they offer relatively generous benefits.[30] Nevertheless, this reduction in costs would not have much effect on the trade balance.

Although prices might fall, the dollar would rise enough to prevent the change in prices from significantly altering the trade balance. Much of the reduction in health spending would be passed on to workers in the form of higher cash wages. Some firms might pass a portion of their health cost savings through to their prices, depending on the market conditions they face. Thus, the prices of tradable goods could fall on average. But these price declines would probably lead to a strengthening of the value of the dollar relative to foreign currencies. A higher dollar would offset the lower costs in industries dealing with tradable goods, keeping the average price of U.S. goods to foreigners about the same.[31] One result would be to share the lower cost of producing tradable goods with the whole U.S. economy by reducing the cost of imported goods.

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29 R. Glenn Hubbard, Jonathan Skinner, and Stephen Zeldes, "The Importance of Precautionary Motives in Explaining Individual and Aggregate Savings," Working Paper 4516 (National Bureau of Economic Research, Cambridge, Mass., November 1993); Martha Starr-McCluer, "Health Insurance and Precautionary Saving" (paper presented at the 1994 annual meeting of the American Economic Association, Boston, Mass., January 1994).

30 See Lewis-VHI, "The Impact of the Health Security Act on Firms Competing in International Markets" (paper presented to the Competitiveness Policy Council, Washington, D.C., December 10, 1993).

31 Henry Aaron and Barry Bosworth, "Health Care Financing and International Competitiveness" (paper presented to the Competitiveness Policy Council, Washington, D.C., December 10, 1993).

As discussed earlier, the Administration's proposal would redistribute insurance costs among different firms and industries, which could alter the prices of their goods and services. These price changes, in turn, could affect the international competitiveness of some companies, although firms whose costs decline by the average for the tradable-goods sector would see no change. For these firms, the reduction of their health costs would be exactly offset by the appreciation of the dollar.

But the international competitiveness of companies with larger-than-average cost reductions would improve. Although the dollar would appreciate, the insurance costs at these companies would fall even more. Firms that have smaller than average reductions—or cost increases—would become less competitive, however.

Conclusion

CBO estimates that the Administration's proposal could cause the number of people working to decline by about one-quarter of a percent to 1 percent, though most of these people would retire or turn to other activities outside the labor market. Unemployment would increase only slightly among minimum-wage workers. A decline in the labor force of that magnitude would reduce the potential market output of the economy by somewhat less, perhaps from 0.2 percent to 0.7 percent. In addition, the proposal would probably cause low-wage workers to move from firms where they would qualify for little or no subsidy to firms where they would attract greater subsidies. Such churning could impose noticeable, though unquantifiable, costs on the economy.

The proposal might also bring into the measured labor force, and measured GDP, some people who are now giving care to their disabled relatives. This would largely be a statistical change and would not significantly alter levels of economic activity.

These predictable changes in the labor force, though important, are in any case small relative to the normal growth and variation in the economy. CBO projects, for example, that the labor force will increase by some 13 percent in the next 10 years, and the predictable effects of the Administration's proposal are well within the range of uncertainty of that estimate. Further, the lower market output of the economy somewhat overstates the economic losses the proposal would cause. Those who left the labor force would engage in other activities—looking after children or enjoying leisure—that have value but are not captured in GDP.

Chapter Five

Other Considerations

The Administration has developed a comprehensive proposal that, if implemented as envisioned by its architects, could alleviate the problems it seeks to address: lack of insurance coverage, lack of access to health care, and rapidly rising health care costs. The proposal's scope is broad, and its attention to detail is extraordinary. It provides a blueprint for restructuring the entire health care system, complete in almost every particular of the design. In this respect it is unique.

As described in Chapter 1, the underlying principles of the proposal would be to establish a universal entitlement to a standard package of health benefits with a financing structure that would build on the existing employment-based system. The proposed system, however, would require all employers to make specified contributions to premiums on behalf of their employees, thereby ending the situation in which some employers in effect pay for the coverage of employees in other firms. All individuals and families, except Medicaid beneficiaries and others with very low income, would also be required to pay at least part of their premiums. Subsidies would be available to help employers and low-income families meet their premium obligations. The Medicaid program as it exists today would end, and Medicaid beneficiaries would enroll in "mainstream" health plans, which would receive the same premium payment for Medicaid beneficiaries as for any other enrollees.

People who had experienced difficulties obtaining health insurance coverage at a reasonable price, and those who feared losing coverage if they lost or changed their jobs, would find that those problems no longer existed. Families with no employed members and employees of small firms would not have to pay higher premiums than others in their community for the same coverage. Employed people would not lose their coverage when they left the labor force. High-risk people in particular would benefit since health status would no longer be a factor in determining the availability of insurance coverage or its price. Most people would have a choice of health plans available to them, which many do not today, and would be provided with information to help them to make informed choices.

To constrain the growth of health care costs, the proposal would establish mechanisms for limiting the rate of growth of premiums for the standard benefit package, and for setting the initial level of premiums in regional alliances. If they were implemented as intended, those mechanisms would be completely effective. The proposal would also attempt to limit federal obligations for subsidies. As discussed in Chapter 2, those limits might not be as effective.

In assessing the likelihood that the Administration's proposal would be able to achieve its goals and establish a stable system for financing health care, two important issues arise: whether it would be possible to implement the proposal fully in the time frame envisioned, and whether there might be unintended consequences that could affect the system's viability.

Policymakers and analysts can only speculate about such questions because of the magnitude of the institutional changes being proposed. The complexity and interrelated nature of the proposal's many components make it difficult to grasp all their possible interactions or to determine the extent of institutional change and development that would be necessary. Moreover, under the proposal an entirely new environment would evolve; the behavior and

expectations of consumers and providers would change in ways that one cannot fully anticipate today. Thus, the potential for unforeseen consequences--both favorable and unfavorable--would be significant.

The Congressional Budget Office's cost estimate, discussed in Chapter 2, assumes that the Administration's restructuring of the health care system would be implemented according to the schedule laid out in the proposal. That assumption may be questionable, however, especially as it relates to the capacity of the agencies that would carry out the program and to the data requirements of the system.

The cost estimate also assumes that the proposed methods for constraining the rate of growth of premiums for the standard health package would be completely effective. Such binding limits could, however, have unintended consequences for the health care system that would affect its overall acceptability and, hence, the sustainability of the limits.

This chapter explores these issues in more depth. The discussion is germane, however, not only to the Administration's proposal but also to any proposal that would involve a major restructuring of the health care system.

Institutional Capabilities and Resources

The organizational structure of the proposed system raises a basic question about its implementation: Would all the agencies involved have the capabilities, experience, and resources needed to undertake their assigned tasks in the time frame envisioned? Many of the critical tasks of setting up the system would be performed by the newly created National Health Board and by the regional alliances, which would be new and untried entities. State and federal agencies would also have major new roles.

The National Health Board would have considerable power and broad responsibilities for the functioning of the entire system, and a large, skilled professional staff would be essential. It would have many difficult tasks to perform--such as establishing a national program for managing the quality of care, developing a national information system for health care, establishing the initial target for the per capita premium for each regional alliance, determining the inflation factor for each regional alliance, estimating the market shares for each health plan in each regional alliance, developing risk-adjustment factors, and recommending modifications to the benefit package.

Moreover, those tasks frequently would have to be performed on extremely tight schedules dictated both by the effective start-up dates and the continuing needs of the proposed system. For example, the board would be required to establish a national program for quality management within one year of enactment and the information system within two years of enactment. On an ongoing basis, the board might have no more than a month in which to determine whether each regional alliance was in compliance with its target for the following year's premiums. After 1996, the board would also have to determine the annual inflation factor and the target for the per capita premium for each regional alliance by March 1 of the preceding year.

The regional alliances--as the frontline agencies responsible for orchestrating the flow of funds through the health care system--would have an even broader, and possibly more demanding, set of responsibilities. They would combine the functions of purchasing agents, contract negotiators, welfare agencies, financial intermediaries, collectors of premiums, developers and managers of information systems, and coordinators of the flow of information and money between themselves and other alliances. They would also have to implement the controls on premiums under the direction of the National Health Board. Any one of these functions could be a major undertaking for an existing agency with some experience, let alone for a new agency that would have to perform them all. Some regional alliances might succeed very well; others might be overwhelmed by these tasks, especially in their early years of operation.

tes would also vary in their capability to assume their new responsibilities. Among other

things, they would be asked to develop standards for and certify health plans, establish guaranty funds, and ensure continued coverage for enrollees who had been in health plans that failed. Consequently, the responsibilities of state insurance regulators would probably expand considerably. But the states vary widely in the legal authority of their insurance departments and in the resources that they now devote to the regulation of health insurance. Whether all states would be prepared to undertake all these activities on schedule is therefore uncertain.[1] The three-year phase-in period, however, would give states the opportunity to increase the capacity of their insurance departments before 1998, if they needed to do so.

States would also play important roles in helping the regional alliances to perform their functions. In particular, they would be required to ensure that alliances received the premiums they were owed and help them to determine eligibility for subsidies for premiums and cost-sharing amounts. Since states would be financially liable for error rates above certain limits when determining eligibility for subsidies, they would have strong incentives to assist alliances with that task. Again, however, it is not clear that they would have the needed resources. The proposal would allow states access to information on tax returns from the Internal Revenue Service to assist them in determining eligibility, but many of the people likely to be eligible for subsidies would not be tax filers.

Interstate cooperation would be essential in order for states to meet their responsibilities effectively. Cooperation would be especially important for handling the complications that could arise in metropolitan areas that crossed state boundaries. The proposal recognizes this issue and includes provisions that would permit states to coordinate the activities of two or more regional alliances—including alliances in different states—in such areas as operating rules, enforcement procedures, fee schedules, and contracting with health plans. Setting up these types of arrangements could be difficult but would be important for the effective functioning of some health care markets.

Similar questions of capacity and resources arise with respect to the Department of Health and Human Services (HHS) and the Department of Labor (DOL)—the two federal agencies that would have major responsibilities under the proposed system. Given the reduction in federal employment that is under way, would HHS have the necessary resources to oversee the financial management of regional alliances and to take over the operation of states' systems if they were seriously out of compliance? Would DOL have the capabilities to oversee corporate alliances and to ensure that employers fulfilled their responsibilities in paying premiums and withholding employees' shares? Presumably, the funding necessary to carry out those functions and develop those capacities would be provided through the normal appropriation process. But in a world of limits on discretionary spending, increased resources for those purposes would mean reductions elsewhere.

Information Requirements

The Administration's proposal would depend critically on timely information, much of which has never been collected. Its data requirements fall into three broad categories: those related to the establishment of the parameters of the system that would determine the payments to health plans, those related to managing the quality of care, and those essential for the day-to-day administration and operation of the alliances and health plans. Notwithstanding the ongoing and rapid development of information technology in the health care industry, it is uncertain whether the data essential for decisionmaking would be available in a timely fashion. If they were not or if important information was of poor quality, the functioning of the system could be compromised.

The proposal recognizes the magnitude of these requirements. The National Health Board would be charged with developing and implementing a national health care information system, which

1. See General Accounting Office, *Health Insurance: How Health Care Reform May Affect State Regulation*, Testimony of Leslie G Aronovitz before the Subcommittee on Health, House Committee on Ways and Means, November 5, 1993, GAO/T-HRD-94-55

would function through an electronic data network based in regional centers. The information system would provide data to meet multiple requirements in such areas as quality assurance, information for consumers and providers, cost containment, and planning and policy development. Establishing even the framework for such an information system within the two-year time period envisioned by the proposal would be a challenge.

Requirements for Establishing Payment Parameters

The National Health Board would need extensive state and local data to develop the adjustment and inflation factors that it would use to determine the target for the per capita premium of each regional alliance. The data required to establish an effective mechanism for adjusting premiums for risk would also be considerable.

The adjustment factors that would be used to establish the initial target for the per capita premium for each regional alliance are supposed to account for the variations in the health spending and insurance coverage of alliances as well as variations in the proportion of spending by academic health centers. Although data on per capita health expenditures would probably be available for states, whether that information would be available for regional alliances is uncertain. Moreover, reliable information on some of the proposed adjustment factors--such as the proportion of people whose insurance coverage was less generous than the standard benefit package--might not be available even for states.

Initially, calculating the inflation factors would require data on the relative changes in the demographic characteristics (age, sex, socioeconomic status, and health status) of the population of each regional alliance compared with those of the population as a whole. The sample sizes of existing national surveys (such as the Current Population Survey) are too small to produce reliable data of these types for all the regional alliances. Either the sample sizes of existing national surveys would have to be increased, or new regional and local surveys would have to be undertaken. Once the alliances were functioning, however, they would probably collect at least some of the demographic data as part of the enrollment process.

Under the proposed health care system, alliances would have to adjust the per capita payments to health plans to reflect the risk status of their enrollees. If that was not done or was not done well, plans that enrolled higher proportions of sicker or riskier individuals would be at a serious disadvantage competing in the new marketplace, and incentives would be strong for plans to engage in subtle forms of risk selection.

The proposal gives the National Health Board the responsibility for developing a methodology that alliances would use to adjust their per capita payments to health plans for risk. The feasibility of developing an effective risk-adjustment mechanism, however, is highly uncertain and depends on the answers to three questions.[2]

- Would it be possible to develop measures that could distinguish the high use of medical services that resulted because some enrollees were poor risks from the higher use that resulted because health plans were poorly managed?
- How precise would such measures have to be in order to keep risk-selection activities by health plans at minimal levels?
- If effective risk-adjustment measures could be developed, would the information needed to implement them be available to alliances and health plans?

The Administration's proposal recognizes the difficulties that could be encountered. For example, the board would be required to establish by April 1995 a method for adjusting payments to health plans prospectively to reflect the risk status of their enrollees, but the proposal contains an alternative should that task prove to be impossible. Specifi-

2. See, for example, Joseph P. Newhouse, "Patients at Risk: Health Reform and Risk Adjustment," *Health Affairs*, vol. 13, no. 1 (forthcoming), and Testimony of Harold S. Luft, Acting Director, Institute for Health Policy Studies, University of California at San Francisco, before the Subcommittee on Health, House Committee on Ways and Means, November 9, 1993.

cally, the board could develop a mandatory reinsurance system for health plans that would remain in effect until a prospective risk-adjustment system was in place.

Requirements for Managing the Quality of Care

The National Health Board would be required to develop a program for managing the quality of care under the direction of a newly created National Quality Management Council. The council would develop national measures of performance relating to the provision of and access to health care services, the criteria for which the proposal specifies in considerable detail. The council would also conduct surveys on access to health care, use of health services, health outcomes, and patients' satisfaction. It would be responsible for providing an annual report to the Congress on the performance of each alliance and health plan and on trends in the quality of health care.

A fundamental precept of the Administration's proposal—one that is shared broadly by health policy experts—is that information on the performance of health plans and providers should be publicly available and in a standardized form that helps consumers to make informed choices. Accordingly, regional and corporate alliances would be required to provide annual reports on each health plan's performance using the standardized measures, including information about individual providers on some of the measures. Those reports would also include results of surveys of consumers on access, outcomes, and satisfaction.

The specifications in the proposal clearly indicate that tracking quality and performance would be a major undertaking for providers, health plans, alliances, and the board, and would greatly expand current reporting requirements. In addition, an inherent tension would exist between the consumers' need for information on which to base their choices and the demands that would be placed on plans and providers to report the required data.

Requirements for Administration and Operations

In order to carry out their basic functions, health alliances would need extensive management information systems and access to national information networks. They would also need the capabilities to conduct surveys and data analyses, or be able to contract for these services. One has only to review the functions that alliances would have to perform to realize that they would require collecting, maintaining, and updating large amounts of information on individuals, employers, and health plans. Examples include:

- Tracking enrollment and disenrollment in different health plans according to the risk characteristics of enrollees and whether they were receiving Aid to Families with Dependent Children or Supplemental Security Income;
- Determining the eligibility of employers and families for premium subsidies;
- Determining eligibility for reductions in cost-sharing amounts;
- Tracking the amounts of cost-sharing payments for low-income people enrolled in high-cost-sharing plans;
- Monitoring the premium amounts owed by families, taking into account their hours of qualified employment and any changes in their type of family that occurred during the year;
- Monitoring the premium amounts owed by employers; and
- Tracking individuals who were eligible to enroll in the regional alliance—such as students or members of two-worker families—but who enrolled in another alliance, and making appropriate payments to those other alliances on their behalf.

The complexity of tracking the flow of people and dollars across alliances' boundaries highlights

the need for some type of national information system. Determining how much families would owe for their health insurance if they moved between alliances during the year would be particularly difficult. According to the proposal, the regional alliance in which a family was enrolled in December (termed the "final" alliance) would be responsible for collecting any amounts owed by the family, regardless of whether the family had lived in the alliance area for the entire year. All the other alliances in which the family had lived would be required to provide the final alliance with the information necessary to determine the family's total liability. Once the final alliance had collected the amount owed, it would have to distribute it equitably to all the alliances involved. Without an automated tracking system, that would be a monumental undertaking.

In addition to collecting and monitoring financial information on individuals and families, regional alliances would have to estimate the demographic characteristics of their eligible populations, including the number of families of each type, the number of extra workers in couples and two-parent families, the proportion of people enrolled in AFDC and SSI, and the number of people in different risk categories. They would also be responsible for estimating the distribution of enrollment across health plans, as well as the total amount of premiums that employers and families should pay and the expected shortfall in premium payments. Those estimates would be of critical importance to the alliance because they would affect the amounts owed by employers and families, the payments made to health plans, and the amount paid by the federal government for subsidies.

The Effects and Sustainability of Controls on the Rate of Growth of Premiums

Under the proposal, the rate of growth of premiums for the standard benefit package would be severely constrained for the 1996-2000 period, after which the rate of increase would be determined by the Congress or, if it failed to act, by a default procedure tied to real per capita economic growth and inflation in consumer prices.

Limiting the rate of growth of premiums would undoubtedly slow the growth of health spending. Thus, even though the proposal would provide universal health insurance coverage and include several new federal program initiatives, CBO estimates that national health expenditures would increase by 94 percent between 1995 and 2004, compared with a projected increase of 108 percent under the CBO baseline. That represents a reduction of $150 billion in 2004. The projected slower growth of spending would occur because of the restraints on premiums, reductions in the Medicare program, and other features of the proposal.

In preparing its cost analysis, the Congressional Budget Office has assumed that the controls on premiums in the Administration's proposal would be implemented as intended and that the mechanisms used to enforce those limits would effectively restrain spending on the services included in the standard benefit package. But what would be the consequences of that restraint, and could it be sustained?

Some experts believe that the targets for premiums could be largely met by increasing the efficiency of the health care system. According to this view, the system has plenty of "fat"—in the form of excess administrative costs and unnecessary use of services—that would be squeezed out by constraining the growth of premiums. Reductions in administrative costs might be achieved by such measures as standardizing claim forms and developing electronic information systems. The unnecessary use of services might be reduced by increasing enrollment in managed care plans and promoting clinically effective methods of treatment.

By contrast, others maintain that even if efficiency improved greatly, achieving the premium targets exclusively by those means would be extremely difficult and that tight constraints could have undesirable effects on the health care system and might prove to be politically untenable. Possible consequences might include reductions in payments to providers and less access to appropriate services for some consumers. The latter might take

the form of longer waiting times for nonemergency services—including visits to physicians, diagnostic tests, and elective surgeries—and reduced access to new high-cost medical technologies if health plans became more selective about the technologies they adopted. As a corollary, research and development in medical technology might slow, and its focus might shift.

At a general level, both views have merits and limitations. Opportunities undoubtedly exist for lowering administrative costs and reducing inappropriate use of services in the health care system, but trimming unnecessary spending might be difficult without increasing spending elsewhere. For example, although the proposal would streamline many aspects of the administration of health services, it also contains provisions that would entail new administrative costs, such as additional reporting requirements for health plans. Increasing enrollment in tightly managed health care plans—such as group- or staff-model health maintenance organizations—might indeed reduce health spending initially but might have little effect on the rate of growth of spending in the longer run. In addition, some of the methods for reducing the unnecessary use of services—such as promoting effective treatments through the use of guidelines for clinical practice—could also result in increasing the appropriate use of services. Although the effects of the use of guidelines on health spending are uncertain, shifting health care resources from less appropriate to more appropriate uses would almost certainly improve the overall quality of health care.

Whether adverse consequences would result under a constrained system is also uncertain. Lower payments to providers and longer waiting times for some services would not necessarily have negative effects on health outcomes, although providers and some consumers would probably be less satisfied. Furthermore, shifting the focus of research on medical technology could yield positive benefits if manufacturers concentrated more on developing lower-cost substitutes for existing technologies and took the likely effects on costs into account when planning new research initiatives.

Ultimately, however, the effects of constraining the rate of growth of premiums would probably play out more at the alliance than the national level. The new system could encompass perhaps 100 to 200 different regional alliances or markets, each facing a target for its per capita premium. The restrictions on premiums might be more constraining in some markets than in others, because the existing degree of competition in those markets and the extent to which health plans and providers have already achieved greater efficiencies vary widely. The limits, therefore, might be much harder to meet in some areas than in others. Furthermore, the effects of the constraints on spending in any particular market would depend on the interrelated behavioral responses of health plans, employers, providers, and consumers in that market to the new incentives in the health care system.

In short, the full effects of limiting the rate of growth of premiums would be highly uncertain. In part, that uncertainty would arise because the restraint on premium growth would occur in a restructured health care system, operating under new incentives and with insurers and health plans facing new forms of restrictions as well as new opportunities. Uncertainty would also stem from the heterogeneity of the regional alliance markets and the probable variation in the ways their health care systems would adapt to restraints on spending.

The fact that limits on the rate of growth of premiums might begin to bite at different times and in different ways in each of the various alliances raises the issue of the political sustainability of those limits: Would the public and policymakers view them as an acceptable way to restrain health care spending? The situation would be particularly difficult because of the wide variation that currently exists in health spending across the country—at least some of which reflects differences in patterns of medical practice and competitive pressures in the marketplace.

On the one hand, to the extent that historical spending is used as the basis for determining the initial level of premiums in regional alliances, limits on the rate of growth of premiums will build in the inequalities in current spending. Some analysts argue that such an approach would be unfair to regions in which the health care system has already become "leaner" and more efficient, since those

regions would have a harder time meeting the growth targets (because they have l "fat" to trim). On the other hand, ignoring historical spending levels and instead establishing initial premium or spending levels according to some objective criteria reflecting need and differences in input prices could cause major disruptions within the health care system in some regions that currently have high rates of use.

The Administration's proposal has recognized both aspects of the problem. The National Health Board would attempt to adjust the regional alliances' targets for premiums to reflect current differences in health spending and insurance coverage. Although this approach would build on historical spending patterns, it would be modified by including the adjustment for insurance coverage. In other words, current spending patterns would be adjusted to account for low spending in an area that may reflect the population's lack of insurance coverage.

The per capita amounts for Medicaid, as well as states' maintenance-of-effort payments for current Medicaid beneficiaries who would no longer be eligible for the program, would also be based on historical spending. In the case of Medicaid, historical differences in per capita spending among regions may reflect differences in covered benefits and in reimbursement rates for providers, as well as variations in access to and use of services.

Under the proposal, the board would be required, by July 1995, to make recommendations to the Congress on:

- Eliminating, by 2002, the variation in regional alliances' targets for per capita premiums that resulted from variations in practice patterns; and
- Reducing, by 2002, the variation in the payments that states would make for beneficiaries receiving cash assistance and for maintenance of effort that resulted from differences in practice patterns, historical differences in the rates of reimbursement to providers, and the amount, duration, and scope of benefits covered by Medicaid.

The Congress would be required to conduct an expedited review of the board's recommendations, which would go into effect unless a joint resolution of disapproval was passed within 60 days. The board's recommendations would be of extreme interest to policymakers because they might have the effect of raising the allowed premium levels in some areas and lowering them in others. The board might also recommend that some states pay more than in the past for Medicaid beneficiaries and maintenance of effort and that others pay less.

CBO's analysis has assumed that the limits on the rate of growth of premiums would be sustained even though they are likely to create immense pressure and considerable tension. Such strains, however, would not be peculiar to the Administration's approach. Other methods of restraining the rapid growth of health care spending would be likely to generate similar stresses.

Conclusion

Fundamental reform of the nation's health care system will inevitably involve many uncertainties. New institutions will be required, and new responsibilities will be imposed on existing institutions. Their abilities to perform will be in doubt. The behavior of providers and consumers will change as incentives are altered. The magnitude and even the direction of these changes are difficult to foresee.

The ramifications and consequences of even incremental approaches to reform are not easy to predict. The complexity of the existing system and the intense interest all Americans have in health care issues make it difficult to anticipate the outcome of even modest changes in existing programs. For example, most policymakers badly misjudged the political response to the Medicare Catastrophic Care Act, and analysts seriously underestimated the fiscal consequences of recent changes in the Medicaid program.

As the Congress considers the Administration's proposal and other alternatives for systemic and incremental reform, the inherent uncertainties of change must be weighed against the detrimental consequences that flow from the current system—increasing numbers of people who lack the security of insurance coverage for health care and the rapidly rising costs of that care.

Appendix

Summaries of Recent Health Care Analyses by the Congressional Budget Office

The Congressional Budget Office (CBO) publications listed below are available to Congressional staff and the general public. To obtain copies, call CBO's Publications Office at (202) 226-2809.

Evaluating the Costs of Expanding the CHAMPUS Reform Initiative into Washington and Oregon (CBO Paper, November 1993, 46 pp.)

In 1988, the Department of Defense (DoD) began the CHAMPUS Reform Initiative (CRI) as a test of managed care in the military. In August 1993, DoD proposed extending a revised version of CRI to Washington and Oregon, certifying to the Congress that CRI would be the most efficient method of providing health care to the two states. As required by law, this paper reviews DoD's analysis. CBO's findings suggest that the revised CRI benefit is likely to cost more than DoD has estimated.

Behavioral Assumptions for Estimating the Effects of Health Care Proposals (CBO Memorandum, November 1993, 37 pp.)

To estimate the effects of proposals to change the health care system, CBO must make assumptions about the behavioral responses that might occur as a result of new policies. This memorandum draws on the best available research to develop a set of guidelines on which to base CBO's estimates. These guidelines will be revised as new evidence appears.

Projections of National Health Expenditures: 1993 Update (CBO Memorandum, October 1993, 22 pp.)

This memorandum provides projections of national health expenditures through 2003. It updates the tables and figures in CBO's study *Projections of National Health Expenditures* (October 1992) based on the methods described in that study and consistent with CBO's September 1993 economic assumptions and baseline budget projections.

Controlling the Rate of Growth of Private Health Insurance Premiums (CBO Memorandum, September 1993, 27 pp.)

This memorandum analyzes two illustrative policy options that are intended to highlight some of the key issues surrounding the regulation of health insurance premiums. The first option is a "stand-alone" measure to limit the rate of increase in private health insurance premiums. The second option incorporates additional policy measures that could mitigate some of the potential adverse effects of a stand-alone policy. (The two options are not based on any specific legislative proposal.)

Estimates of Health Care Proposals from the 102nd Congress (CBO Paper, July 1993, 57 pp.)

The 103rd Congress will be considering a wide range of proposals to expand access to health care and control costs while maintaining quality, and

CBO will have to estimate the effects of these proposals on the federal budget. This paper illustrates CBO's approach to preparing such estimates by examining four health reform bills introduced during the 102nd Congress: H.R. 1300, sponsored by Congressman Russo, establishing a single-payer system; H.R. 5502, sponsored by Congressmen Stark and Gephardt, expanding Medicaid and Medicare and setting overall limits on national health expenditures; H.R. 5919, introduced by the House Republican leadership, embodying much of President Bush's health reform program; and H.R. 5936, introduced by Congressman Cooper and other members of the Conservative Democratic Forum, establishing regional purchasing cooperatives for health insurance and a federal program to subsidize the purchase of private insurance by low-income people.

Trends in Health Spending: An Update (CBO Study, June 1993, 91 pp.)

Since the early 1960s, national health expenditures have risen rapidly despite many attempts to control their growth. This study examines trends in the market for health services since 1960 to provide background information and a context for assessing proposals to change the U.S. health care system. The report focuses on increases in the costs of hospital services, physician services, and drugs and other medical nondurable items. It also compares trends in health spending by the nation with trends in Medicare spending.

Managed Competition and Its Potential to Reduce Health Spending (CBO Study, May 1993, 58 pp.)

This study looks at whether managed competition could constrain spending on health care by motivating consumers, insurers, and providers to be more cost-conscious. The report identifies eight features that are critical for achieving the full savings that managed competition could potentially deliver, including health insurance purchasing cooperatives, caps on contributions by employers, and standardized benefits.

Responses to Uncompensated Care and Public Program Controls on Spending: Do Hospitals "Cost Shift"? (CBO Paper, May 1993, 45 pp.)

During the 1980s, the revenues that hospitals received for treating Medicare and Medicaid patients declined, on average, relative to what it cost hospitals to treat those patients. CBO looks at the extent to which hospitals were able to cover their costs of uncompensated care and their unreimbursed costs of treating Medicare and Medicaid patients during the 1980s with subsidies from state and local governments; sources other than patient care, such as revenues from hospitals' parking facilities and donations; and revenues from private patients

Single-Payer and All-Payer Health Insurance Systems Using Medicare's Payment Rates (CBO Memorandum, April 1993, 60 pp.)

The United States is a leader in medical research and has the ability to deliver health care of the highest quality, but critics find fault with two aspects of the system: a substantial number of people lack health insurance coverage, and health care costs are high compared with countries where coverage is universal. CBO examines two approaches by which both universal health insurance coverage and greater control over health care costs might be achieved. The first approach is a single-payer system in which all covered health care services are insured and paid for by a single insurer, and the second is an all-payer system in which services are covered and paid for by multiple insurers but all payers adopt the same payment methods and rates.

Projections of National Health Expenditures (CBO Study, October 1992, 70 pp.)

The rapid growth of spending on health care will not decrease in the 1990s unless the present health care financing and delivery system is changed. This CBO study reviews the growth in national health spending since 1965, describes CBO's methodology for projecting national health expenditures, and ana-

lyzes trends in spending by type of spending and source of funds.

Economic Implications of Rising Health Care Costs (CBO Study, October 1992, 70 pp.)

This study, a companion to the one above, analyzes how rising health care costs significantly affect the economy by squeezing household and government budgets, distorting the labor market, and diverting resources from other priorities. Because the current health delivery system lacks a mechanism to match benefits with costs, spending on health may not reflect the preferences of either consumers or society. Instead, many factors—detailed in this study—seem to encourage excessive health spending. CBO finds that workers have borne most of the costs of employer-provided insurance in the form of lower real wages and reduced nonmedical benefits. Over the 1973-1989 period, these health costs have gobbled up more than half of the real gains in workers' compensation.

The Potential Impact of Certain Forms of Managed Care on Health Care Expenditures (CBO Memorandum, August 1992, 31 pp.)

This memorandum looks at what might happen to national health expenditures and to spending under Medicare, Medicaid, and private health insurance if all acute care services now funded through insurance arrangements were provided through delivery systems incorporating two specific forms of managed care. One is staff-model and group-model health maintenance organizations. The other is "effective" forms of utilization review, which CBO interprets to mean utilization review that incorporates precertification and concurrent review of inpatient care.

The Potential of Direct Expenditure Limits to Control Health Care Spending (CBO Memorandum, July 1992, 17 pp.)

This memorandum describes various approaches to using expenditure limits to control health spending and identifies some of the operational issues that would be involved.

The Effects of Managed Care on Use and Costs of Health Services (CBO Memorandum, June 1992, 32 pp.)

This memorandum assesses the evidence about the effect of managed care organizations and interventions on the use and costs of health services—both for the affected populations and for the entire health care system—focusing on managed care for acute care services.

Selected Options for Expanding Health Insurance Coverage (CBO Study, July 1991, 100 pp.)

About one in seven Americans lacks health insurance. This study explores three options to expand health insurance coverage for the uninsured mandating job-based coverage, expanding the Medicaid program, and combining the two. Each of these options could substantially reduce the ranks of the uninsured and keep most existing insurance arrangements intact, the study finds, but spending on health care could rise considerably.

Rising Health Care Costs: Causes, Implications, and Strategies (CBO Study, April 1991, 110 pp.)

This study describes the economic factors that contribute to the growth in health spending and examines what is known about the effectiveness of different strategies for achieving greater control over costs. The five strategies examined by the study are cost sharing by consumers; managed care that limits the freedom of health care providers and consumers; price controls; efforts to increase competition among insurers and providers; and regulation of the market for health services, including controls on capital and uniform payment systems that encompass all payers.

Updated Estimates of Medicare's Catastrophic Drug Insurance Program (CBO Study, October 1989, 73 pp.)

This study estimates the cost to Medicare of covering outpatient prescription drugs as required by the Medicare Catastrophic Coverage Act of 1988. The methodology described in this report remains applicable to estimates of proposals to provide a prescription drug benefit under Medicare.

GRADUATE SCHOOL OF BUSINESS
STANFORD UNIVERSITY, STANFORD, CALIFORNIA 94305

ALAIN ENTHOVEN
MARRINER S. ECCLES PROFESSOR
OF PUBLIC AND PRIVATE MANAGEMENT

January 18, 1994

Robert Reischauer, Ph.D
Director, The Congressional Budget Office
Congress of the United States
Washington, DC 20515

Dear Bob:

This letter responds to the recent CBO document "Behavioral Assumptions for Estimating the Effects of Health Care Proposals" (November 1993), and to CBO estimates that managed competition would not appreciably reduce health care costs. It makes four main points:

I. **CBO has made an important error in interpreting the research it cites on the premium price elasticity of demand of health plan choice, an error that makes all the difference between whether markets can or cannot discipline prices. The error may have led CBO to the wrong conclusion.**

Consider an illustrative example. HMO A charges a premium of $100 per month. Employers in its area contribute $90. HMO A decides to cut price by $1.00. The result in the next open season is a 6 percent increase in the HMO's membership. What does that imply about the price elasticity of HMO A's demand curve?

The CBO answer is that a 10 percent price cut (as seen by the consumer) produces a 6 percent increase in membership. Therefore, HMO A's demand curve elasticity at this point is an inelastic -0.6. In that case, of course, HMO A would have no incentive to reduce price. The contrary would be the case. The market would not drive it to reduce cost and price.

On the other hand, the answers of Bryan Dowd, Roger Feldman and W. Pete Welch [1], [2] - the authors whose work is cited in the CBO document in Table 3, page 10 - and my answer, would be that a 1 percent price reduction (as seen by the HMO, i.e., the price-maker) produced a 6 percent increase in membership. Therefore, HMO A's demand curve - the one relevant to its price-

making decision - is an elastic -6.0, ten times greater. In that case, depending on its marginal cost, HMO A's reward for cutting price is likely to be a whole lot stronger. If HMO A started with 100 members, the $1 price cut would increase membership to 106 and total revenue from $10,000 to $10,494.

Bryan, Roger and Pete explained this point in their articles. The econometrics were done using the consumer out-of-pocket price only. But the correct inference regarding the relevant demand elasticity for price determination must be based on the HMO's total price. In a letter to Sandra Christensen (copy enclosed), Bryan and Roger conclude CBO understated the elasticities they found by a factor of 16.5. Pete's article explained the same point, and he estimated employer contributions averaged about 90 percent of premium. Thus, CBO underestimated the elasticity implied by his findings by a factor of 10.

Though these much greater elasticities may not make intuitive sense to people who observe today's marketplace, the discrepancy can be explained by the fact that, because of common employer practices and the tax code, most people do not face a situation in which they must pay a full dollar more out of pocket if they choose a health plan that costs a dollar more. Of course, under managed competition they would.

The significance of this difference in price elasticity is not merely the numbers of people who would switch to HMOs. Experience in competitive situations suggests that very high percentages of people would switch in order to save money, if they get to keep the savings. CalPERS benefificiaries are now 80 percent in HMOs; most of the rest are in geographic areas not yet served by HMOs. We think that with adequate incentives, HMOs will expand into these areas. At Stanford this year, we became 100 percent HMO (one with a point-of-service option) for all employees living in the local area.

The main significance of the high elasticity of demand is that a price competitive environment would motivate Accountable Health Plans to reduce cost over the long run.

There is much such organizations can do to cut cost while maintaining or improving quality: study variations in practice patterns from the point of view of cost and outcomes and adopt the least costly way of producing the best outcome; match numbers and types of doctors and other resources to the needs of the population served; concentrate costly complex procedures like open heart surgery in high-volume regional centers; substitute less costly personnel for routine tasks within their competence; and practice continuous quality improvement along the lines practiced by Xerox and Hewlett Packard.

Studies of the savings that have been generated by HMOs, such as the 28 percent reduction in resource use by Group Health Cooperative of Puget Sound, compared to fee-for-service in the RAND study, are not an adequate indicator of what could be done over time in a price-competitive environment because, to date, HMOs have not had to operate in such an environment. But experience in other high-tech industries shows that competition over quality and price can motivate large cost reductions.

CBO's error could explain why CBO reached the conclusion that the Managed Competition Act of 1992 would not reduce health care costs appreciably. Since the issue was the efficacy of market forces, which turn decisively on demand and supply elasticities, I assume these understated demand elasticities were factored into the CBO model.

II. CBO's use of studies based on 1982 and 1984 data impart a substantial downward bias in the estimated price elasticity of demand, and gives us, at best, a lower bound estimate of what price elasticity would likely be today.

The Welch study - a pathbreaker for its time - used 1982 BLS data, when there were 10.8 million HMO members as opposed to today's 45 million. That makes a large difference because the presence of competing HMOs, i.e., close substitutes, increases the price elasticity of each HMO's demand curve. Furthermore, greater familiarity with and market acceptance of HMOs that has occurred since 1982 would raise price elasticity. Moreover, because of data limitations, Welch was limited to examining the elasticities between conventional plans and the largest prepaid group practice in each market, and not the multiple HMO situations that characterize most metropolitan areas. Yet, again, the presence of multiple HMOs increases each HMO's price elasticity of demand.

III. Managed competition as proposed by the Jackson Hole Group,[4] and largely adopted by Cooper-Grandy, and by Clinton, proposes to generalize a set of elasticity-enhancing measures, that have been applied successfully in local situations, to the whole health care economy. Somehow you should take account of that in your estimates.

Here are the proposed general principles and procedures:

1. Everybody participates in an annual "open season" enrollment in which, at a single time and place, they have all alternatives presented to them for choice, with accurate and binding information on price.

2. Virtually everyone is in an Accountable Health Plan, so choice of managed care plan becomes the norm, and plans become closer substitutes.

3. Full subscriber responsibility for premium price differences, as applied at Stanford, recently adopted by the University of California, in place since 1986 for Minnesota State employees, etc. Employers required to make level dollar defined contributions, as in the Clinton plan.

4. Limit on tax-free employer contributions set at the price of the low-priced qualified plan in the region, so subscribers pay premium differences with after-tax dollars.

5. Standardize the benefits package to facilitate value comparison, prevent product differentiation and market segmentation, and to prevent fear of "air pockets" or hidden gaps in coverage from deterring decisions to change plans.

6. Risk adjust premiums, at least by demographic variables.

7. Individual choice (vs. group choice) of plan so those who are willing to change doctors and plans to save money can do so even if co-workers are not.

8. Systematic production of information on consumer experience and quality of care in all plans.

I described all this in some detail, *inter alia*, in two articles in *Health Affairs* in 1993. [5],[6]

All of these measures have been demonstrated in pieces around the country. The proposed policy is to put it all together in a coherent program. The combined effect of all these measures is very likely to be a large increase in price elasticity of demand compared to the 1982 and 1984 results.

IV. The combined effect of more and larger HMOs and similar managed care plans, greater market acceptance, and managed competition is difficult to estimate. We are talking about new terrain. There is uncertainty, just as there is uncertainty about the true efficacy of President Clinton's proposed premium price controls. The best way for CBO to handle this is honestly to admit that there are large uncertainties in both cases, and perhaps to handle the elasticity issue parametrically, giving us a range of estimates following from a range of assumptions.

I suggest you begin with a 16.5-fold increase in the Dowd and Feldman results, a 10-fold increase in the Welch estimates as recommended by the authors. Then test the effect of some substantially greater elasticities to reflect changed market conditions and the measures of managed competition. Re-run your models with these modified assumptions. If your models are robust, new runs should show the significant cost-reducing effects of competition.

Best wishes.

Sincerely,

Alain Enthoven

REFERENCES

[1] Welch W.P. From Table 3. Price Elasticity Estimates for Choosing Among Plans with Similar Benefits, *Congressional Budget Office Memorandum,* Nov. 1993. p.10.

[2] Feldman R, Finch M, Dowd B, Cassou S.. The Demand for Employment-Based Health Insurance Plans. *The Journal of Human Resources* Vol.24 (1) Winter 1989., pp.115-142. The University of Wisconsin Press.

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[5] Enthoven A. The History and Principles of Managed Competition. *Health Affairs* Vol. 12 Supplement 1993, pp. 24-48.

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CONGRESSIONAL BUDGET OFFICE
U.S. Congress
Washington, DC 20515

Robert D. Reischauer
Director

February 9, 1994

Professor Alain Enthoven
Graduate School of Business
Stanford University
Stanford, CA 94305

Dear Alain:

Thank you for your letter of January 18, in which you discussed a recent CBO document "Behavioral Assumptions for Estimating the Effects of Health Care Proposals" (November 1993). We have many areas of agreement. In fact, a number of your points have been made in various CBO documents in recent years.

There is one crucial point--concerning the price elasticity of demand for insurance--on which we disagree, however. You apparently believe that the larger value of the elasticity concept you propose (defined with respect to total premium, instead of with respect to the enrollee's share of the premium) would translate into greater enrollment implications from any given change in the premium. This is not so. The implications for the change in plan enrollment using your total-premium elasticity are identical to those using our employee-share elasticity, when each concept is used correctly. Hence, estimates would be identical whether we used our elasticity concept or yours. The attached numerical example should make this clear.

In any case, we use this employee-share elasticity only to estimate the effects of policy changes that would result in relatively small changes in the price of insurance with no other significant changes in the environment in which decisions to purchase are made. When estimating HMO enrollment growth under managed competition proposals, we do not use the elasticities shown in Table 3 of the CBO document because these proposals envision a substantial restructuring of the health insurance market that might alter behavior so significantly that estimates based on the current structure would be inappropriate. Instead, as mentioned on page 12 of CBO's November paper and on page 10 of our July document ("Estimates of Health Care Proposals from the 102nd Congress"), we rely on experience under the insurance plans for public employees in California and Wisconsin--which are similar to managed competition proposals--to estimate the amounts by which HMO enrollment would grow. Our use of the California and Wisconsin experience, and our reasons for it, seem to be in accord with the views expressed in your letter.

I hope this clears up your confusion over CBO's estimating assumptions.

Sincerely,

Robert D. Reischauer

c. Roger Feldman
Bryan Dowd

EXAMPLE

Consider the following situation, using data from a study by Feldman and others that shows the estimated change in market share for a given "nest" or type of plan when its premium is increased:[1]

INITIAL VALUES

1.	Total monthly premium	$62.09
2.	Employee share of premium	$3.74
3.	Market share of plan	50.00%

CHANGE IN VALUES

4.	Total monthly premium	$5.00
5.	Employee share of premium	$5.00
6.	Market share of plan	-10.60%

PERCENTAGE CHANGES

7.	Total monthly premium	8.05%
8.	Employee share of premium	133.69%
9.	Market share of plan	-21.20%

CALCULATED ELASTICITIES

A.	wrt total premium (#9/#7)	-2.6335
B.	wrt employee share of premium (#9/#8)	-.1586

Elasticity A is 16.6 times as large as elasticity B, but the implications for the change in the plan's market share are identical. If you choose to use the larger elasticity concept A, then the appropriate price change to use is correspondingly smaller (8.05%). If you use the smaller elasticity concept B, then the relevant price change is larger (133.69%). Thus, the calculated effect on market share is the same whether you use elasticity A or B.

Using elasticity A: Percentage change in market share = -(2.6335)*(.0805) = -21.2%.

Using elasticity B: Percentage change in market share = -(.1586)*(1.3369) = -21.2%.

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1. R. Feldman and others, "The Demand for Employment-Based Health Insurance Plans," *Journal of Human Resources*, vol. 24 (Winter 1989), Table 4.

COMMUNICATIONS

STATEMENT OF THE EXECUTIVE INTELLIGENCE REVIEW

"Launch the Emergency Economic Measures Necessary to Meet the Goal of Universal Health Care at the 'Hill-Burton standard' for All"

The most laudable part of the Administration's health care reform package is, as taken from President Clinton's statements, the goal of providing universal health care. However, the 3000+ page Health Security Act, and the commentary to date, fall far short of initiating the physical and related means to meet that goal. At worst, measures are proposed to merely aid private financial interests—through federal budget-cutting and insurance maneuvers, that will only make the general economy, and health care delivery, even worse than at present.

We therefore offer these three points for consideration in analyzing the existing proposal, and taking action for what is required:

(1) The country is right now in a state of crisis in terms of public health care, essential infrastructure and the general economy.

(2) The post-war "Hill-Burton Act" type of health care system, involving public and private collaboration, insurance arrangements, etc. is the model that should be used again.

(3) To provide adequate health care, the physical means for delivery can only come from a rejuvenated economy, which, in turn requires national economic emergency measures.

PUBLIC HEALTH CARE CRISIS

The state of crisis in the general health condition of the nation can be seen in the resurgence of once-controlled infectious diseases, and the spread of AIDS. This has come about as general poverty increased, at the same time as the adequacy of vital services—safe water, sewage treatment, inoculation programs, good nutrition, adequate housing, has declined drastically. In the more or less contiguous parts of the Eastern Seaboard megalopolis, there are whole areas of poverty where people have been turned into host zones for the spread of diseases, and incubation of new mutations. An example of this is the spread of drug-resistant tuberculosis.

On top of this, the availability of medical essentials for specialized treatment has also drastically declined, in terms of beds per thousand persons, equipment per thousand persons, trained personell, etc.

Therefore, if tomorrow all funding problems were suddenly solved, and people were informed to go out and get what services or treatment they required, they couldn't get it, because it physically doesn't exist.

The physical health care delivery system in the nation has been "downsized" along with the general economy.

PROVIDE "HILL-BURTON" STANDARDS OF UNIVERSAL CARE

Following World War II, the standards of medical care and public health embodied in the Hill-Burton Act were implemented in many parts of the country, with good results. Those standards are applicable today.

Basically, the guideline is, "If you need doctoring, you get it." This is for your good, and for the protection of the general population. Besides being disease-free, we want to prolong life, so that wherever skills, wisdom and inspiration may be had—in particular from the elderly, they are passed on for the good of society.

For example, the according to the recommended number of beds-per-thousand persons, by the late 1970s, the U.S. stood at 97 percent of that goal.

However, by the late 1980s, the U.S. had fallen short, by meeting only 83 percent of that goal. By January, 1994, we have fallen farther still.

Over the 1980s, 761 hospitals were shut down. The import of these declining numbers of beds per thousand people is not that out-patient care and healthier people have made beds redundant. People just aren't getting care. Look at Germany in comparison. Today, Germany has more than 7.4 beds per 1,000 people, which is nearly DOUBLE that of the United States.

The same type of physical standard should be used for all other essentials of providing medical care.

WHERE DO THE BEDS COME FROM?

The only way to support the medical system necessary for universal health care is to mobilize the general economy, creating the physical means, the tax base and supporting the skilled manpower to succeed. Although overall economic policy is not the topic in the Committee's series of hearings on Administration's health reform proposal, nevertheless, the condition of the economy is the relevant issue.

Briefly, the steps required are (1) Declare a national economic emergency for reasons of the manifest unemployment, disease rate, infrastructure and related crises. (2) Nationalize the Federal Reserve Bank system which for decades has backed speculative financial practices, at the expense of the real, physical economy. (3) Initiate a national infrastructure-building program, including inputs for an adequate medical care delivery system and public health system. These and related measures (such as imposing a tax-penalty on derivatives trading and other speculation now destroying the economy), will in turn result in a demand for employment on the scale of 6–8 million jobs in productive activity, and set up a chain reaction of orders for bills-of-materials inputs that can resuscitate industrial life.

For example, look at the impact on the construction industry of carrying out the right health care "reform" program. Millions of new square feet of floor space need to be built. At present, the annual rate of construction of new hospital floor space, on a per capita basis, is 20 percent below where it was in the 1960s.

(A detailed analysis of the scope and rate of decline in the U.S. physical economy over the past 30 years, using the extensive EIR economic database, is available in a series in the January/February/March, 1994 issues of the weekly EIR, which will supply on request).

WHO WILL PAY?

When you "needed doctoring" in the period of the Hill-Burton Act hospitals, you got what was required. Then it was figured out how to pay the bill. To start with, the number of weeks' of wages needed to pay the bill of the average hospital stay in the 1950s was 1.2 weeks. Today, it is over 12 weeks and rising.

If you didn't have the means, the relevant people would figure something out in the course of meeting the community's needs. Private and public officials met periodically on such bills, on planning for future facilities, etc. Blue Cross/Blue Shield and some other plans did not cost an arm-and-a-leg, and played a role.

With a functioning economy and tax base, this is the model that can and should work again.