CBO TESTIMONY

Statement of
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NOTICE

This statement is not available for public release until it is delivered at 10:00 a.m. (EDT), Tuesday, April 23, 1991.

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Mr. Chairman, I appreciate the opportunity to appear before this Committee to discuss health insurance coverage in the United States and approaches the Congress might take to expand it.

In March 1990, an estimated 33.4 million people--or 13.6 percent of the population--were without health insurance coverage. Because insurance coverage for people 65 and over is nearly universal through Medicare, most of the uninsured--33.1 million-were under age 65. About three out of five uninsured people are poor or near-poor, with income less than 200 percent of the poverty threshold.

These figures understate the problem. Estimates for 1987 indicate that the number who were uninsured at some time during the year was about 30 percent higher than the number who were uninsured during the first quarter of the year. If the same was true for 1990, then nearly one in five among the population under 65 were uninsured at some time during the year, and about one in ten were uninsured for the entire year.

The problem of inadequate insurance coverage is exacerbated by our inability to slow the growth in health care costs. Cost increases are raising premiums for health insurance faster than the growth in national income, thereby further eroding coverage. Since 1980, the proportion of the population under 65 without health insurance has increased by 25 percent.

REASONS FOR LACK OF HEALTH INSURANCE

Health insurance in the United States is provided through a mix of employment-based, public, and individual insurance plans. Our system evolved over the last 60 years, as health insurance gradually became widespread. At the same time, however, it changed from a mechanism designed to spread risk across broad groups to one that often isolates and denies protection to those most at risk for large health care costs. In each locality, what was once a single "community" of insured people has been fragmented into discrete populations facing group-specific premiums. This fragmentation has reduced the extent to which those with lower expected costs subsidize those with higher expected costs. Larger employers can buy coverage for their workers readily at standard rates or can self-insure. But premiums for small employers and for individual applicants are now most often based on the insurer's assessment of specific risk factors for the group or person to be covered--a process called medical underwriting.

For about 70 percent of the population under 65, insurance is largely based on employment. Hence, lack of insurance among the population under 65 is best explained in reference to their work force connections.

Nearly one in five among the uninsured under 65 have no work force connection--that is, no one in the family is employed. Among this group, individuals ineligible for benefits under a retiree health plan, Medicaid, or Medicare must purchase insurance in the private market or do without. Some choose to do without insurance because the coverage offered to them is unattractive--typically being more restrictive and more expensive than employment-based coverage. Others are denied insurance coverage altogether, either because of a preexisting medical condition or because of other risk factors.

About two-thirds of the uninsured are in families in which at least one person works full time, and another 13 percent have a part-time work force connection. But those in families with only part-time workers are two and one-half times more likely to be uninsured than those in families with at least one who works full time. Most firms do not provide health insurance to part-time employees even when they offer it to full-time workers. As a consequence, many of those with only a part-time work force connection must turn to the individual insurance market for coverage.

Even those with a full-time work force connection do not always have access to employment-based insurance. About 43 percent of firms offer health insurance to their employees (at least to those who work full time), and

these firms employ about 77 percent of the work force. This means, however, that employment-based health insurance is not offered to 23 percent of the work force.

Smaller firms-those with fewer than 25 employees--are less likely than others to offer health insurance. These firms experience a number of problems in the insurance market that distinguish them from larger employers. In fact, many of the problems faced by small employers are similar to those faced by individuals seeking insurance. The coverage offered to them by insurers is typically more expensive and more restrictive than that offered to larger employers. Firms with fewer than 25 employees account for less than 30 percent of the work force, but for more than half of the uninsured workers. Some additional information on health insurance will be found in the tables in Appendix A.

APPROACHES TO ACHIEVING GREATER INSURANCE COVERAGE

The proposals intended to increase insurance coverage that I will discuss today fall into five broad categories: tax subsidies for the purchase of private insurance; changes in the regulation of the private insurance market; additional requirements on employers to provide employment-based insurance; expansion of public insurance to selected groups; or a universal

public health insurance program. I will describe one illustrative option for each of these five approaches, discussing in each case the likely effects of the option on the number of people with health insurance and on spending for health. The estimated effects are presented in the tables in Appendix B.

Tax Subsidies for the Purchase of Private Insurance

Under current law, the federal income tax code provides a substantial subsidy for health insurance, with income tax expenditures of about $40 billion for 1992. The principal subsidy is the exclusion of qualified employer-paid health insurance premiums and certain other health costs from workers' income for tax purposes. In addition, low-income workers are eligible for a refundable tax credit on the purchase of health insurance that covers their children. This credit is for all premium costs, subject to a ceiling equal to 6 percent of qualified earnings. For 1991, the maximum credit will be $428.

The current system of tax subsidies could be expanded to make the purchase of private health insurance less expensive. The tax system could also be used to promote other goals of health policy, especially cost containment. For example, some current proposals would combine tax subsidies with a cap on the value of employer contributions to health plans that could be excluded

from income for tax purposes, in order to encourage the purchase of plans with less generous benefits. Tax options that would address goals other than access, however, are outside the scope of my remarks today.

Illustrative Option. A refundable tax credit for the purchase of a qualified private insurance plan could be made available to all people with income below 200 percent of the poverty threshold. Specifically, the tax credit for all those with adjusted gross income less than 100 percent of poverty would equal 25 percent of the amount paid in premiums for private insurance. The credit would be gradually reduced from 25 percent of premiums for those with income at the poverty level to zero for those with income above 200 percent of poverty. The credit would be available both for the purchase of individual insurance policies and for the employee share of premiums for employment-based policies.

The increase in insurance coverage would be very limited under this option, because a 25 percent subsidy would induce little additional purchase. Poor and near-poor people would have difficulty contributing much toward the purchase of insurance, and their incentive to contribute is reduced by the availability of charity care. Most of the subsidy would go to the 30 million people below 200 percent of poverty who already purchase some private insurance, rather than to the 20 million who are uninsured.

The increase in national spending for health care would be small, reflecting the small increase in insurance coverage. Federal spending for health (including tax expenditures) would increase appreciably, however, because of the benefit the credit would give to those who already purchase insurance. There would be a small drop in both federal and state spending under Medicaid for the medically needy. Health spending by individuals (net of the credit) would fall, while health spending by employers would increase a little as some additional workers elected to participate in employment-based health plans because of the credit.

Variants. Variants might either raise or cut the percentage of premiums that would apply toward the credit, or they might expand or reduce the groups eligible for it. If the credit was increased to cover a large percentage of premium costs, this approach could significantly reduce the number of uninsured among the eligible population. This would be a costly way to increase coverage rates, however, as much of the benefit would go to those who are already insured.

Regulatory Changes in the Private Insurance Market

In recent years, the availability of affordable insurance for high-cost groups and individuals has been reduced because insurers have used enrollment and rate-setting provisions to fragment the market into populations grouped by risk, reducing the subsidy of high-cost groups by low-cost groups. Regulatory changes--at either the state or federal level-could be used to restrict insurers' enrollment and rate-setting practices. By limiting the amount that premiums for high-risk applicants could exceed premiums charged to others, this approach could make health insurance more affordable for those at risk for large health care costs.

Illustrative Option. One option would require all insurers to hold an open enrollment period for one month each year, when insurers would have to accept all individual and group applicants at advertised rates. The rates could vary by benefit design, geographic area, age, and sex, but not by health status or previous claims experience. Insurers would be permitted to impose a six-month waiting period for preexisting conditions on those who were previously without insurance, but no waiting period could be imposed on those who were changing insurers with no break in coverage.

Because high-cost cases might not be proportionately distributed among insurers, a reinsurance mechanism could be necessary to help insurers manage their risk under this option. An industry-based nonprofit reinsurance corporation could be set up, financed partly by premiums paid by insurers seeking reinsurance and partly by premium-based assessments on all health plans (including those that were self-insured, which would require changes in federal legislation).

It is uncertain whether overall insurance coverage would increase or fall under this option, but continuity of coverage would improve because of the restriction on insurers' use of waiting periods before preexisting conditions would be covered. The cost of insurance would fall for high-risk applicants, thereby probably inducing higher coverage rates for them. But the cost of insurance would increase for lower-risk groups, perhaps reducing their coverage rates by enough to completely offset the increase in coverage among high-risk groups.

Even if there was no overall increase in insurance coverage, national spending for health care might increase somewhat because of the reorientation of insurance coverage toward high-risk people, who would be likely to use more health care services. Federal and state government costs under Medicaid would probably fall, primarily because of reduced spending

for "medically needy" groups. (Medically needy people are those who become temporarily eligible for Medicaid benefits in some states when their income exceeds their health care costs by less than the state's income standard for eligibility.) The overall effects on spending for health by individuals and by employers are uncertain, as changes in spending among high-risk groups would be offset by changes among low-risk groups.

Variants. Current proposals include a number of variations on this option, most of which would either add to or reduce the factors insurers might use to vary rates, thereby affecting the extent of cross-subsidy that would take place among the insured population. The greatest increase in cross-subsidy would occur with "pure" community rating, which would establish the broadest possible risk pool in each community--a single individual rate and a single family rate for each benefit package offered by the insurer. A much smaller increase in cross-subsidy would occur under proposals that would limit--but continue to permit--medical underwriting and experience rating.

Employer Mandates

Because rates for group health insurance are generally substantially lower than rates charged to individual applicants, access to affordable health

insurance could be increased if employers were required to offer health insurance to their employees. Workers affected by the mandate would be required to accept employment-based coverage for themselves and their dependents.

Illustrative Option. The option examined here would require all firms with 10 or more employees to offer a qualified health insurance plan to each employee who works 25 hours or more a week, and to the employee's dependents. When both members of a couple would be affected by the mandate, they could choose which employer's plan to accept to avoid duplicate coverage. Qualified plans would provide benefits that were actuarially equivalent to, or better than, those of a model plan specified by law. Employers would be required to pay at least 75 percent of the premium costs.

If this option had been in place for 1990, the share of the population with insurance would have increased from 86.4 percent to as much as 94 percent. The greatest increase would occur among children and adults under 55. These estimates assume no reduction in employment as a result of the mandate, although some reduction probably would occur. This result would be especially likely among low-wage workers, because in their case it would be more difficult for employers to reduce other components of the

compensation package in response to a mandated increase in health insurance benefits.

National spending for health would increase by about 2 percent as a result of the expansion in coverage. Federal spending for health (exclusive of employee health benefit costs) would fall by about 2 percent, because new employment-based benefits would replace some spending under Medicare and Medicaid. The net effect on the federal budget would be a small increase in the deficit, however, because tax receipts would fall by somewhat more than federal health spending would. (This result assumes that employers would shift compensation from taxable wages to nontaxable health benefits, with no change in overall compensation for workers.) Health spending by state/local governments (exclusive of employee health benefit costs) would fall by about 4 percent because of reduced spending for Medicaid and for uncompensated care in public hospitals, but state tax revenues would also drop. Health spending by individuals would decline by about 3 percent because of expanded insurance coverage and because employers would pay a larger share of premium costs. Initially, employers' health plan costs would rise by about 14 percent, on average, although the effects of the mandate would be concentrated most on firms with at least 10 but less than 25 employees. Over time, the increase in employers' costs would be negligible, as employers would

reduce other components of workers' compensation to offset the increase in health benefits.

Variants. Current proposals differ in how comprehensive the mandate to provide health insurance would be, and how it would be applied. If fewer exemptions were permitted under the mandate, a larger proportion of workers would be offered insurance, but a very comprehensive mandate might threaten the continued viability of some firms--especially those that had a large proportion of low-wage or part-time workers. One variant designed to address this trade-off would give employers the option of paying a payroll-based tax for some or all employees instead of providing health insurance directly. In this instance, adverse effects on employment for part-time and low-wage workers would be smaller, but the excluded workers would be less likely to obtain health insurance. Employers' tax payments would have to be combined with contributions from excluded workers and perhaps with a government subsidy for the purchase of health insurance.

Medicaid Expansion

Instead of attempting to make the purchase of private health insurance more affordable, coverage rates could be increased by offering free or subsidized

public insurance to selected groups not now eligible for it. The expansion could be through Medicaid, Medicare, or a new program, but the illustrative option is for an expansion of Medicaid. Currently, Medicaid covers only 42 percent of the poor, and 11 percent of those with income between 100 percent and 200 percent of the poverty line.

Illustrative Option. This illustration would extend Medicaid coverage without cost to all poor individuals and families. Current categorical eligibility conditions and asset limits would be dropped. People with income between 100 percent and 200 percent of the poverty thresholds would be permitted to buy into Medicaid by paying an income-related premium, which could not exceed one-third of Medicaid's insurance value. (The maximum premium for a family of three would be about $1,260 for 1991.) Each state's usual benefit package would be provided. As under current law, Medicaid would be a secondary payer to employment-based insurance and to Medicare.

Under this option, the share of the population with insurance would increase to as much as 95 percent. Coverage would rise the most for children and for women of prime child-bearing age (25-44). Medicaid would become the primary payer for nearly 40 million people, compared with only 15 million people currently.

If all those newly eligible for Medicaid accepted it, national spending for health would grow by nearly 2 percent because of the increased use of services generated by the new coverage. Higher costs under Medicaid would raise federal health spending by about 8 percent, and state health spending would increase by about 9 percent. Health spending by individuals would fall by about 7 percent, while the effect on employers' health spending would be negligible.

Variants. One variant of this approach would restrict the expansion of Medicaid to certain demographic groups below some specified income level, rather than extending it to all people meeting the income criteria. Relative to the illustrative option, such restrictions would reduce the costs of the expansion if the same income criteria were used. Alternatively, the restrictions could permit the expansion of Medicaid to higher income groups for no greater cost than the illustrative option.

Universal Public Health Insurance

Instead of trying to eliminate gaps in coverage within our current patchwork system of insurance, we could achieve universal coverage by implementing a public health insurance plan for which all people would be eligible. It could

be a federal program or state programs set up under federal guidelines (similar to the Unemployment Insurance program).

Illustrative Option. The plan described here would replace all existing insurance for acute-care services with a new public insurance plan for which all legal residents would be eligible. The benefit package would be actuarially equivalent to the average benefits currently provided under private plans and Medicare. Providers would be paid on the same terms as those now in place under Medicare, financed from broad-based federal and state taxes. Private insurance plans would be prohibited from offering any benefits covered by the public plan, including a prohibition on paying the public plan's copayment requirements (which would be capped). Private plans would, however, be permitted to offer coverage for services not covered by the public plan.

Costs for both the new public insurance program (which would replace Medicare) and for a residual Medicaid program would be shared by federal and nonfederal governments in roughly the same proportion as public spending for health is shared now. For those currently eligible for Medicaid, the residual program would pay the copayments required under the public plan and the costs of long-term care.

Under this option, insurance coverage for acute-care services would be universal. Continuity of coverage for benefits provided under the public plan would be assured because enrollees would never have to change insurers regardless of changes in their work force connections.

It is uncertain whether national spending for health would increase or fall, on balance, under this option. Spending for health care services would increase initially because of comprehensive insurance coverage and higher payment rates for some services previously paid by Medicaid, only partly offset by lower payment rates for services previously paid by private insurers. On the other hand, administrative costs would fall because of the replacement of the many payers in our current system with a single payer. Overall, estimates for the initial change in national health spending range from approximately -7 percent to 2 percent.

Health spending by federal, state, and local governments would increase initially by up to 85 percent under this option, because most spending for acute care services would be transferred to the public sector. If national spending for health fell under this option, though, the increase in government spending would be less than the drop in private-sector spending. Hence, the private sector could be financially better off in the aggregate, even assuming taxes were increased by enough to pay the new governmental costs. (Tax

revenues would automatically rise some, if compensation employers had previously provided as nontaxable health benefits was paid as taxable earnings instead.) The distribution of benefits and costs would change, however, so that some individuals and employers could be financially worse off.

Variants. One variant of this approach would permit private insurers to cover the public plan's copayment requirements, in addition to services not covered by the public plan. This change would permit enrollees to improve on the public plan's benefits for covered services, but would also increase the plan's costs by encouraging greater use of services. Other variants of this approach would introduce a public insurance program as an alternative health plan in which people could enroll if they preferred it to private insurance. This alternative would be less disruptive than wholesale replacement of current insurance arrangements and would preserve choice among plans, but it would also continue the high administrative costs of the current system. If the public plan was fully financed by enrollees' premiums, it would probably become the insurer of last resort, eventually enrolling only those deemed uninsurable in the private market who had sufficient income to pay the premiums.

CONCLUSION

Insurance coverage would be most improved under a universal public insurance plan, and least improved by regulatory changes in the private insurance market, although both approaches could ensure that insurance was universally available even if not universally accepted (see Table 1). Substantial but incomplete increases in coverage could be achieved through either new employer mandates or expansion of Medicaid. A tax credit could increase insurance coverage appreciably only if it was substantial relative to the cost of insurance, and even then most of the credits would go to those who would have purchased insurance anyway.

The initial change in national spending for health resulting under each of these five approaches would be only roughly correlated with the size of the newly insured population. Even if no new coverage was generated by regulatory changes for private insurance, spending for health would probably increase somewhat because the composition of the insured population would change to include a higher proportion of high-cost people. Although there would be more newly insured people under the Medicaid expansion--compared with the employer mandate--the increase in national health spending would be no higher than it would be under the mandate because Medicaid's payment rates are lower than those paid by private insurers.

TABLE 1. ESTIMATED EFFECTS OF SELECTED APPROACHES TO INCREASING HEALTH INSURANCE COVERAGE (In percent)

	Approaches to Increasing Coverage				
	Tax Subsidies	Regulatory Changes[a]	Employer Mandate[b]	Medicaid Expansion[c]	Universal Plan[d]
Characteristics of Insurance Coverage					
Maximum percent insured	88	86 to 87	94	95	100
Continuity	Unchanged	Improved	Unchanged	Unchanged	Assured
Initial Change in Spending for Health					
Nationwide	Small Increase	Small Increase	2	2	-7 to +2
Federal government	Increase[e]	Small Decrease	-2	8	70 to 85
State/local governments	Small Decrease	Small Decrease	-4	9	70 to 85
Individuals[f]	Decrease	Uncertain	-3	-7	-40 to -30
Employers[g]	Small Increase	Uncertain	14	0	-100
Other Effects on the System					
Potential for cost control	Unchanged[h]	Unchanged[h]	Unchanged[h]	Unchanged[h]	Improved
Change from current system	Small	Moderate	Moderate	Small	Large

SOURCE: Congressional Budget Office, from the 1989 National Health Expenditure Accounts and the March 1990 Current Population Survey.

NOTES: See the tables in Appendix B for more information on each option.

a. Assumes no government subsidies would be provided.
b. Assumes no change in overall employment or in full-time employment would occur.
c. Assumes all those eligible for Medicaid would apply for benefits.
d. Spending would be at low end of range if potential savings in administrative costs were fully realized and use by formerly uninsured increased by only one-third; spending would be at high end of range if administrative savings were only partially realized and use by formerly uninsured increased by two-thirds.
e. Increase results from tax expenditures for credit; tax expenditures are not usually counted as government spending in national health expenditure accounts.
f. Includes out-of-pocket costs and individual's share of premiums, less value of tax subsidies.
g. Includes government spending for employee health benefits.
h. Potential could be improved if comprehensive and coordinated payment policies were implemented by all payers.

Insurance coverage would increase the most under a universal insurance plan, but national health spending might increase relatively little or not at all in the short run, if the savings potential related to administrative costs was fully realized.

Over the long term, the effects on national spending for health could be different, either more or less favorable, for each of the approaches examined. The potential for cost control could be improved under any of the approaches discussed here if comprehensive and coordinated payment policies--addressing both the volume and the price of services--were adopted by all payers in each locality. Implementing such policies would be straightforward under a universal insurance plan, but similar policies could be implemented in a system with multiple payers as well. If comprehensive and coordinated payment policies were put in place, and if effective use was made of their potential to control costs, national spending for health could fall over time, relative to what would be spent under our current system. Otherwise, growth in national health spending might continue at its current rate or might even grow faster.

Both the tax subsidy approach and the Medicaid expansion would transfer additional resources to low-income groups, while the regulatory changes in the private insurance market would instead transfer resources from

lower-risk groups to those at high risk for large health care expenses. A universal public insurance plan would also transfer resources from lower-risk to high-risk groups; it could also transfer resources among income groups in a variety of ways, depending on how it was financed. The redistributive effect of the employer mandate would be negligible in the long run, because employers would reduce other components of workers' compensation to offset any increase in health benefits. In the short run, however, employers not now offering health insurance could encounter financial difficulties.

Unlike the other approaches, a universal public insurance plan would be a radical change from our current system. It would disrupt most current health insurance arrangements and would reduce the role of private insurers, in favor of a greatly expanded government role. By contrast, an expansion of tax subsidies for health insurance or an expansion of Medicaid would have little effect on the private insurance system, at least if expansions were limited to low-income groups. Regulatory changes and employer mandates would occupy a middle ground. Both would increase federal involvement in the regulation of health insurance significantly, but would represent incremental changes in the current financing system.

APPENDIX A

TABLE A-1. HEALTH INSURANCE COVERAGE BY AGE, 1990
(In millions)

Group	Total Population	Insured		Uninsured		
		Number	Number As Percentage of People in Group	Number	Number As Percentage of: People in Group	Number As Percentage of: Total Uninsured
Total Population	246.2	212.8	86.4	33.4	13.6	100.0
65 or over	29.6	29.3	99.0	0.3	1.0	0.9
Under 65	216.6	183.5	84.7	33.1	15.3	99.1
Under 65 by Age of Individual						
Under 18	64.3	55.8	86.7	8.5	13.3	25.6
18 to 24	25.3	19.0	74.9	6.4	25.1	19.0
25 to 44	80.4	67.9	84.4	12.6	15.6	37.6
45 to 64	46.5	40.9	88.0	5.6	12.0	16.8

SOURCE: Congressional Budget Office, from the March 1990 Current Population Survey.

TABLE A-2. SOURCES OF HEALTH INSURANCE COVERAGE FOR THE POPULATION UNDER 65, 1990 (In millions)

Source of Primary Coverage	Number Covered	Number As Percentage of Population Under 65
Employment-based	150.6	69.5
Medicare	3.0	1.4
Medicaid	14.6	6.7
Veterans Affairs	0.8	0.4
Other Private	14.6	6.7
Insured Population	183.5	84.7
Uninsured Population	33.1	15.3

SOURCE: Congressional Budget Office, from the March 1990 Current Population Survey.

TABLE A-3. SOURCES OF HEALTH INSURANCE FOR POPULATION UNDER 65, BY WORK FORCE CONNECTION, 1990 (In millions)

Group	Number	Uninsured		Percentage of People in Group Insured by Primary Source:					
		Number	As a Percentage of Total Uninsured	As a Percentage of People in Group	Employer	Medicare	Medicaid	Veterans Affairs	Other Private	Total Insured
With Connection to Labor Market	186.8	26.6	80.6	14.3	76.1	0.4	2.4	0.3	6.6	85.7
Full-time	173.4	22.4	67.6	12.9	78.8	0.3	1.7	0.2	6.1	87.1
Part-time	13.4	4.3	12.9	31.9	41.0	2.3	10.9	0.8	13.2	68.1
No Connection to Labor Market	29.8	6.4	19.4	21.6	28.6	7.3	34.0	0.9	7.7	78.4
All	216.6	33.1	100.0	15.3	69.5	1.4	6.7	0.4	6.7	84.7

SOURCE: Congressional Budget Office, from the March 1990 Current Population Survey.

NOTES: Workers and their dependents have a work force connection; others do not. For those with a work force connection, the connection is classified as full time if anyone in the family works full time.

TABLE A-4. AVAILABILITY OF EMPLOYMENT-BASED HEALTH INSURANCE PLANS, BY SIZE OF FIRM, 1989

Size of Firm (By number of employees)	Percentage of Firms Offering	Percentage of Employees in Firms Offering
Under 25	39	55
Under 10	33	42
10 to 24	72	70
25 to 99	94	94
100 to 499	99	97
500 to 999	100	100
1,000 and Over	100	100
All Firms	43	77

SOURCE: Congressional Budget Office, from the 1989 Employer Survey by Health Insurance Association of America.

TABLE A-5. UNINSURED WORKERS UNDER 65, BY SIZE OF FIRM, 1990

Size of Firm (By number of employees)	Number of Workers (In millions)	Number As Percentage of Total Uninsured Workers	Percentage of Workers in Group Who Are Uninsured
Under 25	8.2	51.1	25.0
25 to 99	2.4	14.9	16.2
100 to 499	1.8	11.2	11.3
500 to 999	0.5	3.1	7.7
1,000 and Over	3.2	19.7	7.3
All Firms	16.1	100.0	14.2

SOURCE: Congressional Budget Office, from the March 1990 Current Population Survey.

APPENDIX B

TABLE B-1. ESTIMATED EFFECTS OF AN INCREASE IN TAX SUBSIDIES FOR THE PURCHASE OF PRIVATE HEALTH INSURANCE

Characteristics of Insurance Coverage	
Availability	Unchanged from current law
Percent covered	
Overall	Small increase
By group	Higher for low-income groups eligible for credit
Continuity	Unchanged from current law
Initial Change in Spending for Health	
Nationwide	Small increase, because of increase in coverage among those eligible for credit
Federal government	Increase in expenditures for credit; small reduction in spending for medically needy
State/local governments	Small reduction in spending for medically needy under Medicaid
Individuals	Decrease in unsubsidized premium costs for groups eligible
Employers	Small increase for employers with workers eligible for credit

SOURCE: Congressional Budget Office.

NOTES: The specific option examined would provide a 25 percent refundable federal income tax credit for purchase of health insurance to all poor people, phased out to 0 for those with income of more than 200 percent of the poverty level.

TABLE B-2. ESTIMATED EFFECTS OF CHANGES IN REGULATORY REQUIREMENTS FOR PRIVATE INSURERS

Characteristics of Insurance Coverage	
Availability	Universal during open enrollment period
Percent Covered	
Overall	Small change--could increase or decrease
By group	Higher for high-risk groups; lower for low-risk groups
Continuity	Improved, because of limits on insurers' use of waiting periods for preexisting conditions
Initial Change in Spending for Health	
Nationwide	Small increase, because of better coverage for high-risk groups
Federal government	Small reduction in spending for medically needy under Medicaid
State/local governments	Small reduction in spending for medically needy under Medicaid
Individuals	Decrease for high-risk groups; small increase for low-risk groups
Employers	Decrease for high-risk groups; small increase for low-risk groups

SOURCE: Congressional Budget Office.

NOTES: The specific option examined would require open enrollment for one month each year, for coverage during the following calendar year. Advertised rates during the open enrollment period could vary only by area, age, sex, and benefit design. Reinsurance would be provided through an industry-based nonprofit corporation, with excess costs financed by premium-based assessments on all health (including self-insured) plans.

TABLE B-3. ESTIMATED EFFECTS OF AN EMPLOYER MANDATE FOR THE PROVISION OF INSURANCE

Characteristics of Insurance Coverage	
Availability	Available to all with a full-time work force connection in a firm with 10 or more employees
Percent covered	
Overall	Increased by up to 7.2 percentage points, from 86.4 percent to 93.6 percent
By group	Greatest increase for children and adults under 55
Continuity	Unchanged
Initial Change in Spending for Health	
Nationwide	Higher by up to 2 percent
Federal government	Reduced by about 2 percent, because of lower spending for Medicare and Medicaid
State/local governments	Reduced by about 4 percent, because of lower spending for Medicaid and public hospitals
Individuals	Reduced by about 3 percent
Employers	Higher by about 14 percent

SOURCE: Congressional Budget Office.

NOTES: The specific option examined would require all firms with 10 or more employees to provide health insurance to full-time workers and their dependents. All those working 25 hours or more a week would be deemed full-time. Employers would pay at least 75 percent of premium costs.

TABLE B-4. ESTIMATED EFFECTS OF AN EXPANSION OF MEDICAID TO NEW GROUPS

Characteristics of Insurance Coverage	
Availability	Available to all with income less than twice poverty
Percent covered	
Overall	Increased by 8.3 percentage points, from 86.4 percent to 94.7 percent
By group	Greatest increase for children and women under 45
Continuity	Unchanged
Initial Change in Spending for Health	
Nationwide	Higher by up to 2 percent
Federal government	Higher by up to 8 percent
State/local governments	Higher by up to 9 percent
Individuals	Reduced by about 7 percent
Employers	Unchanged

SOURCE: Congressional Budget Office.

NOTES: The specific option examined would extend Medicaid benefits at no cost to all poor individuals and families. Those with income between 100 percent and 200 percent of the poverty line could buy into Medicaid through an income-related premium, which could not exceed one-third of Medicaid's insurance value.

TABLE B-5. ESTIMATED EFFECTS OF IMPLEMENTING A UNIVERSAL PUBLIC INSURANCE PLAN

Characteristics of Insurance Coverage	
Availability	Universal
Percent Covered	
Overall	Increased by 13.6 percentage points, from 86.4 percent to 100 percent
By group	Greatest increase for young adults
Continuity	Problem eliminated
Initial Change in Spending for Health	
Nationwide	Estimates range from decrease of 7 percent to increase of 2 percent
Federal government	Increased by 70 percent to 85 percent
State/local governments	Increased by 70 percent to 85 percent
Individuals	Reduced by 40 percent to 30 percent
Employers	Reduced by 100 percent

SOURCE: Congressional Budget Office.

NOTES: The specific option examined would extend acute-care benefits to all legal residents at no premium cost. Private insurance coverage for covered services would be prohibited. Costs of the new public plan and of the residual Medicaid program would be shared by federal and nonfederal governments.