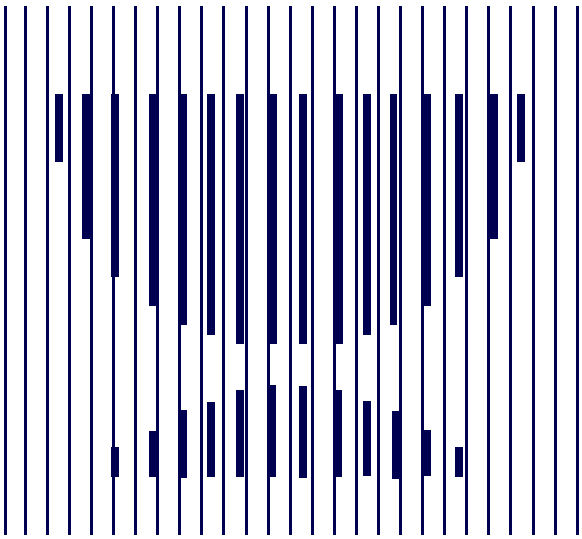
CBO MEMORANDUM

A QUALITATIVE ANALYSIS OF THE HERITAGE FOUNDATION AND PAULY GROUP PROPOSALS TO RESTRUCTURE THE HEALTH INSURANCE SYSTEM

April 1994



CONGRESSIONAL BUDGET OFFICE

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THE HERITAGE FOUNDATION AND
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CONGRESSIONAL BUDGET OFFICE
SECOND AND D STREETS, S.W.
WASHINGTON, D.C. 20515

Illustrative numbers presented in this memorandum have been rounded for ease of exposition.

This Congressional Budget Office (CBO) memorandum was prepared in response to requests from Senator Pete V. Domenici, the Ranking Minority Member of the Senate Committee on the Budget, and Senator J. James Exon, also a member of that committee. It describes and analyzes two proposals to restructure the health insurance system. The Heritage Foundation made one; Mark Pauly, Patricia Danzon, Paul Feldstein, and John Hoff made the other. The memorandum does not estimate the costs of either proposal.

The memorandum was prepared by Kevin Quinn of CBO's Health and Human Resources Division, under the direction of Nancy Gordon and Linda Bilheimer. Within CBO, valuable comments were provided by B.K. Atrostic, Leonard Burman, Sandra Christensen, Robert Dennis, Harriet Komisar, Rosemary Marcuss, Murray Ross, and Roberton Williams. Carol Frost undertook the programming for the numerical illustrations shown in Appendix B. The Actuarial Research Corporation provided the premium estimates used in the memorandum. Outside CBO, valuable comments were made by Stuart Butler, Patricia Danzon, Allen Feezor, Edmund Haislmaier, James Mays, Mark Pauly, and Katherine Swartz.

Sherwood Kohn edited the manuscript. Ronald Moore prepared the final version, and Christian Spoor proofread it. Questions about the analysis may be directed to Linda Bilheimer at (202) 226-2673.

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CHAPTER I

SUMMARY AND INTRODUCTION

This memorandum is a qualitative analysis of two proposals that would require everyone in the United States to obtain health insurance, restructure the incentives inherent in the tax system, and set national standards for the pricing and marketing of health insurance. One proposal has been made by the Heritage Foundation; its chief authors are Stuart Butler and Edmund Haislmaier. The other proposal has been made by a group associated with the American Enterprise Institute; it is composed of Mark Pauly, Patricia Danzon, Paul Feldstein, and John Hoff. For the sake of brevity, this group is referred to here as the Pauly group. Adoption of either proposal would cause profound change to the nation's health sector, while maintaining the sale of insurance and the delivery of health care as private-sector activities.

The memorandum is not a Congressional Budget Office (CBO) cost estimate of either proposal, nor does it consider how aspects of the proposals might be treated in the federal budget. The calculations presented here are intended only to illustrate how the proposals might operate.

THE HERITAGE PROPOSAL

Although the Heritage Foundation first presented its proposal in 1989, it substantially revised it in the latter part of 1993. In November 1993, legislation resembling the revised Heritage Consumer Choice Health Plan, but different in several significant ways, was introduced by Senator Don Nickles as S. 1743 and by Congressman Cliff Stearns as H.R. 3698. It should be emphasized that this memorandum is an analysis, not of these bills, but of the revised Heritage proposal, which is summarized in Appendix A. That proposal calls for full implementation on January 1, 1997.

In order to guarantee universal health care coverage, everyone would have to obtain insurance, either through a government program or from a private insurer, on their own or through a family member. The states would be charged with enforcing the mandate and would have to arrange coverage for people who did not do so themselves. The minimum insurance would cover "catastrophic" health care expenses--that is, those exceeding $1,000 a

year for an individual or $2,000 a year for a family. (Those amounts would be adjusted for inflation after 1997.)

To help make the coverage affordable for people who did not qualify for Medicare or other government programs, the proposal would establish a new, refundable tax credit that would depend on a family's health expenses as a percentage of its income. The credit would equal 25 percent of that portion of health expenses that were less than 10 percent of adjusted gross income (AGI), plus 50 percent of that portion of expenses between 10 percent and 20 percent of AGI, plus 75 percent of that portion of expenses that exceeded 20 percent of AGI. "Health expenses" would be made up of premiums for the required coverage, premiums for any supplementary insurance plans, and out-of-pocket spending on a broad range of health services. A new federal/state program, designed by each state, would assist people with family income under 150 percent of the poverty threshold whose health expenses exceeded 5 percent of AGI even after the tax credit was taken into account.

The three tax provisions that now subsidize health expenses would be repealed. The most important is the exclusion from employees' taxable income of health insurance premiums paid by an employer. Furthermore, taxpayers could no longer deduct health expenses that exceeded 7.5 percent of AGI, and employees covered by certain types of flexible benefit plans could no longer use pretax income to pay premiums and out-of-pocket expenses.

The change in subsidies would have important consequences for almost everyone who is not covered by a government health program. Current law offers the largest tax subsidy to people whose employers pay their premiums as part of their compensation, and this subsidy is greatest for employees who have generous insurance coverage and high marginal tax rates. Out-of-pocket spending is now subsidized only for employees enrolled in certain types of flexible benefit plans and for people who itemize deductions and whose health expenses exceed 7.5 percent of AGI. People who buy insurance on their own do so with after-tax income and are eligible for a subsidy only if their health expenses exceed 7.5 percent of AGI.

By contrast, the proposed tax credit would be unaffected by employment status, would treat premiums and out-of-pocket spending similarly, and would offer the greatest subsidy to those people whose health expenses were high in relation to their incomes. The proposed credit would also encourage spending on health compared with spending on other items in the household budget, since all privately insured families would receive a subsidy equal to at least 25 percent of their health expenses.

The proposal calls for other changes that would contribute to a restructuring of the employment-based health insurance system that is in place today. The federal government would take over much of the regulation of health insurance from the states, requiring that insurers unconditionally accept all applicants and that premiums vary only with the age, sex, and geographic residence of the policyholder. Group-purchasing discounts would be allowed; how these discounts would be regulated would determine whether premium variability would be as limited in practice as the proposal advocates. If such discounts were tightly regulated, insurers would have less ability than they do now to select the pool of people they would cover and would have greater incentives to control the price and volume of the health care services that their policyholders used.

Employers would not have to offer health insurance benefits to their workers, but those that currently offer such benefits would have to pay out the value in cash to their employees, who could buy coverage anywhere they pleased. As a result, health insurance would become more of an individual purchase than is the case today, with consequent increases in marketing costs borne by insurers. Employers that self-insured would become subject to the regulations facing insurers in general, including the requirement to accept any applicant, not just those connected with their work force. They would therefore be much less likely to operate plans themselves.

The impacts on families would depend on the interplay of many variables, some of which are exceptionally difficult to predict. In general, lower-income people would benefit more than those with higher incomes, and people with higher health expenses would benefit more than those with lower expenses. People who now have employment-based insurance would see an increase in the proportion of their total compensation that was subject to taxation, but would benefit from the tax credit. The net effect would depend on their circumstances. People who now buy insurance on their own would become better off financially, since they would receive the tax credit without an offsetting increase in their payroll and income tax liabilities. The uninsured would have to buy insurance, the cost of which would be only partly offset by the subsidy and could be a considerable burden. People covered by Medicare, Medicaid, the military health services system, and similar programs would not be directly affected; if they became ineligible for government coverage, they would receive the subsidy and face the mandate in the same way as everyone else.

The chief costs to the federal government of carrying out the proposal would result from the proposed tax credit and the proposed federal/state program for people with low incomes. The cost of the credit would depend on spending in a health sector quite different from what we see today, making

estimation very difficult. The new federal expenditures would be offset by revenue from eliminating the current subsidies as well as by changes in the Medicare and Medicaid programs that would reduce federal spending below what it otherwise would have been. The most notable changes would be imposition of a cap on part of the federal contribution to Medicaid and the proposed elimination of payments by Medicaid and Medicare to so-called disproportionate share hospitals. This memorandum contains no estimate of whether carrying out the proposal would, on balance, increase or decrease the federal deficit.

THE PAULY GROUP PROPOSAL

The Pauly group places more emphasis than does the Heritage proposal on maintaining today's employment-based insurance system and on removing taxes from the list of considerations that people weigh in making decisions.[1] The group's proposal also is not as completely specified, which makes some of its effects unclear. The authors say the proposal could be carried out all at once or in stages. For example, a ceiling on employer-paid premiums excluded from employees' taxable income could be progressively lowered, with revenues from the cap devoted to gradually expanding the proposed new subsidy.

Again, universal health care coverage would be achieved by requiring that each individual obtain insurance. The Medicaid program would no longer cover acute care for people under 65 years old, so beneficiaries would have to obtain subsidized private insurance. The mandate would be enforced through the taxation and welfare systems; the proposal does not describe the responsibilities of the various levels of government more precisely. The Congress would determine the minimum plan necessary to satisfy the mandate; at one point, the authors suggest coverage similar to that now offered by a health maintenance organization.

The three tax subsidies for health spending under current law would be repealed, to be replaced with a refundable tax credit that would depend on a family's expected health expenses, not its actual expenses as under the Heritage proposal. For a family of average risk status whose income was below the poverty threshold (estimated to be about $11,800 for a family of

1. Principal expositions, all written by Mark Pauly, Patricia Danzon, Paul Feldstein, and John Hoff, are *Responsible National Health Insurance* (Washington, D.C.: AEI Press, 1992); "A Plan for 'Responsible National Health Insurance'," *Health Affairs*, vol. 10, no. 1 (Spring 1991), pp. 5-25; and "How We Can Get Responsible National Health Insurance," *The American Enterprise* (July/August 1992), pp. 61-69.

three in 1994), the credit would equal 100 percent of the premium for the minimum plan. The value of the credit would decline as income rose, to reach zero at a point between three and five times the poverty threshold (or between about $35,500 and $59,100 for a family of three in 1994). Families whose risk status was above or below the average would receive a credit adjusted for factors such as age, sex, geographic residence, and health status. The adjustment process is otherwise unspecified; questions about the design of such a process raise perhaps the most significant issues about the proposal.

Since the credit would be unaffected by how much a family actually spent on health, families would have stronger incentives than under the Heritage proposal to economize in purchasing insurance and paying out of pocket for health care. In sharp contrast to the situation today, the amount of money a family spent on health and the way in which it spent it would have no effect on its tax liabilities.

In its proposed changes to the insurance market, the Pauly group takes a position almost opposite to that of the Heritage Foundation. The Pauly group would allow insurers to charge any premiums they wished to new policyholders, a practice known as pure risk rating. Insurers would face limits, however, in the premium increases they could charge people renewing their policies. To allow insurers this scope, the federal government would have to preempt the growing number of state laws that limit the variation in premiums charged to individuals and small groups. Under such a system, insurers would have little incentive to seek out low-risk applicants and avoid high-risk applicants, since everyone could be charged premiums that reflected their risk levels. Insurers would presumably use risk rating to a greater extent than they do now, since any that did not do so could be at a competitive disadvantage. This matching of premiums to risk levels could require a substantial expenditure of resources, however. If pure risk rating proved to be impractical, the proposal says that limits on premiums could be instituted.

Employers would not be required to pay their employees' health insurance premiums, but those that did so would have to report the value to the Internal Revenue Service. In contrast to the Heritage proposal, employers would not have to "cash out" health insurance benefits to their workers, and if they chose to offer insurance they could require all employees to be insured through the workplace. As a result, insurers would probably continue to regard employment-based groups as relatively predictable portfolios of risk, reducing the need to expend resources on risk assessment. Employers would continue to be able to restrict coverage to their employees, spouses, and dependents.

The proposal's net impacts on families whose risk status differs from the average cannot be analyzed. How much the family would have to pay for insurance would depend on whether it was part of a group and how the insurer geared premiums to risk levels. In theory, the tax credit would vary among families to parallel these differing premiums, but the unspecified nature of the tax credit makes it impossible to draw inferences about the operation of the subsidies.

Since people above certain income levels would receive no tax credit, the inverse relationship between income and the subsidy would be stronger than under the Heritage proposal, holding other factors constant. The proposal would also unambiguously benefit people who now buy insurance on their own, while requiring uninsured people above the poverty threshold to spend more on insurance than they would receive from the tax credit. The impacts on people who now have employment-based insurance would depend on their individual circumstances.

The chief cost to the federal government would be the proposed tax credit; the magnitude would depend on premium levels set by specific types of insurers and on the process for adjusting the tax credit for risk status. In total or in part, this cost would be offset by increased tax revenue from the elimination of existing subsidies.

CHAPTER II

DESCRIPTION OF THE HERITAGE AND PAULY GROUP PROPOSALS

The Heritage and Pauly group proposals would both change the health insurance system profoundly. They would also have substantial impacts on the delivery of health care, but these impacts would be indirect and are not discussed at length by the proponents. The proposals have many similarities, though there are important areas of difference (see Table 1).

COMMON ELEMENTS

The proposals share three essential elements: a mandate on individuals to obtain health insurance, the replacement of current tax provisions that subsidize health spending with a single broad-based provision, and the introduction of a strong federal role in determining which pricing and marketing practices health insurers could and could not follow.

Mandate on Individuals

Under the provisions of both proposals, everyone would be required to obtain health insurance from either a public program or a private plan, in their own name or as another person's dependent. (The Pauly group proposal refers only to citizens, although the mandate presumably would apply to resident aliens as well. Neither proposal specifies whether the mandate would apply to citizens living abroad.) The Heritage Foundation lists the applicable public programs as Medicare, Medicaid, the military health services system (which covers active-duty personnel, military retirees, and dependents), the Department of Veterans Affairs' medical system, and the Indian Health Service. The Pauly group proposal does not list specific public programs other than Medicare.

Under the Heritage proposal, states would identify and arrange coverage for people who did not obtain coverage for themselves; states could charge these people premiums based on the cost of coverage and the individual's ability to pay. To assist the states, employers would be required to report workers who did not have proof of insurance.

TABLE 1. COMPARISON OF THE HERITAGE AND PAULY GROUP PROPOSALS WITH THE CURRENT HEALTH CARE SYSTEM

	Current Law	Heritage Proposal	Pauly Group Proposal
Individual Mandate	None.	Everyone must have at least minimum benefit plan. States responsible for identifying and arranging coverage for people without insurance.	Everyone must have at least minimum benefit plan. Mandate enforced through taxation and welfare systems; no specification of federal and state roles.
Minimum Benefit Plan	None.	"Catastrophic" coverage of medically necessary acute care services, with deductible of $1,000 (individual) or $2,000 (family) and stop-loss limit of $5,000. No coinsurance rate specified.	Coverage of acute and preventive care; also, out-of-pocket expenses limited to a percentage of income. No further details provided.
Supplementary Insurance	Not applicable.	Anyone may buy insurance to supplement the minimum benefit plan; premiums receive the same tax treatment as premiums paid for the minimum benefit plan.	Anyone may buy insurance to supplement the minimum benefit plan; premiums receive the same tax treatment as premiums paid for the minimum benefit plan.
Tax Subsidies Related to Health	1) Employer-paid benefits are excluded from employees' taxable income. 2) Employees in certain flexible benefit plans may use pretax income to pay premiums and out-of-pocket expenses. 3) Taxpayers may deduct health expenses over 7.5 percent of adjusted gross income.	1) Replaced with refundable tax credit, varying with income and health expenses (defined as the sum of premiums paid for minimum and supplementary plans and out-of-pocket health expenses). 2) Repealed. 3) Repealed.	1) Replaced with refundable tax credit, varying with family income, demographics, and health status. It would not vary with actual health expenses. 2) Repealed. 3) Repealed.

(Continued)

TABLE 1. CONTINUED

	Current Law	Heritage Proposal	Pauly Group Proposal
New Program	Not applicable.	Federal/state program for low-income people with high health expenses.	Not applicable.
Role of Medicare Program	Cover acute care for the elderly and certain people with disabilities.	Continue current program. Eventually, enrollees could receive vouchers with which to choose their own plan.	Continue current program. Eventually, the proposed system could replace Medicare.
Role of Medicaid Program	Cover acute and long-term care for certain groups of low-income people.	Continue current program. People who become ineligible for Medicaid buy insurance and receive tax credit.	Acute care benefits eliminated for people under age 65; Medicaid beneficiaries buy subsidized minimum benefit plan.
Regulatory Roles	States have strong roles; federal law regulates self-insured employers.	Federal government sets standards that states administer.	Federal law allows insurers broad latitude in setting premiums.
Insurance Regulation	Varies widely among the states; regulation of premiums is common, especially in the individual and small-group markets.	Premiums vary with age, sex, and geographic residence; discounts may reflect lower marketing costs to groups; guaranteed issue; guaranteed renewal.	Pure risk rating allowed for initial premiums; if impractical, replaced with limits on premiums. Insurers restricted in setting renewal premiums.
Role of Employers	At employer's option, arrange and pay for insurance.	At employer's option, pay for insurance. Report value of benefit to Internal Revenue Service in line with demographic categories. Must "cash out" current benefits to employees. Cannot require participation in own plan.	At employer's option, arrange and pay for insurance. Report value of benefit to Internal Revenue Service; can choose valuation method itself. Need not allow employees to "cash out" current benefits. May require participation in own plan.

(Continued)

TABLE 1. CONTINUED

	Current Law	Heritage Proposal	Pauly Group Proposal
Positive Impacts on the Federal Budget (Relative to Current Law)	Not applicable.	Elimination of tax exclusion, health-related flexible benefit plans, and deductibility of health expenses; cap on federal Medicaid payments; elimination of Medicare and Medicaid payments to disproportionate share hospitals; certain Medicare changes.	Elimination of tax exclusion, health-related flexible benefit plans, and deductibility of health expenses; reduction in payments for Medicaid acute care services.
Negative Impacts on the Federal Budget	Not applicable.	Tax credit; new federal/state program; possible increase in popularity of non-health fringe benefits.	Tax credit; increased popularity of non-health fringe benefits.
Positive Impacts on State Budgets	Not applicable.	Possible increase in tax revenue; elimination of payments to disproportionate share hospitals; possible drop in uncompensated care.	Possible increase in tax revenue; reduction in payments for Medicaid acute care services; possible drop in uncompensated care.
Negative Impacts on State Budgets	Not applicable.	Arranging coverage for uninsured people; responsibility for paying Medicaid costs that exceed federal cap; contributions to new federal/state program.	Possibility of (unspecified) requirements by federal government to maintain current funding effort.

SOURCE: Congressional Budget Office.

The Pauly group proposal does not specify the responsibilities of the various levels of government, saying only that the mandate would be enforced through the taxation and welfare systems, which include a wide range of programs administered by all levels of government. People who did not choose an insurance plan themselves would be assigned to a "fallback" insurer, which would be a private-sector insurer that agreed to accept all applicants and to charge them premiums that depended on unspecified risk characteristics. A government agency would select the fallback insurer through a bidding process. Employees who did not demonstrate proof of coverage to their employer would be assigned to the fallback insurer and have premiums withheld from their paychecks. Similarly, uninsured people who receive checks from government programs such as welfare and unemployment assistance would have premiums withheld from those checks. The proposal does not include a way to enforce the mandate for people who do not have income from a job or from a government program. Although the proponents believe this group would be a negligible fraction of the population, there could be those who would avoid receiving such income if it meant that they became liable for the premiums.

Under either proposal, the federal government would determine the contents of the minimum benefit plan that people would need to meet the mandate. The comprehensiveness of the plan would be the single greatest determinant of its cost, which in turn would affect the affordability of the mandate for families and the impact on government finances. Under either proposal, anyone could also buy insurance to supplement the minimum plan. Premiums paid for supplementary coverage would receive the same tax treatment as premiums paid for the minimum plan.

Under the Heritage proposal, the minimum benefit plan would provide only "catastrophic" coverage; that is, it would protect policyholders only against the cost of large medical expenses. Under current law, a family with a typical employment-based plan might be responsible for the first $400 of medical expenses a year, an amount known as the deductible. Once the deductible had been reached, the family might pay coinsurance equal to 20 percent of its additional expenses for covered services. Its maximum liability, or stop-loss limit, for both the deductible and coinsurance might be $1,000 to $2,000. The Heritage proposal, by contrast, calls for a deductible of $1,000 for an individual and $2,000 for a family, with a stop-loss limit of $5,000 in either case. No coinsurance level is specified; as a result, insurers marketing to policyholders who were willing to accept higher risk in return for lower premiums could use coinsurance rates higher than the 20 percent rate common today. In the extreme case, a coinsurance rate of 99 percent would make the deductible equal to $5,000 for all practical purposes. For the purposes of the illustrative calculations in this memorandum, the Congres-

sional Budget Office (CBO) has assumed that the typical policy would include a coinsurance rate of 20 percent.

Under the Heritage proposal, the minimum benefit plan would have to cover all acute care services that were medically necessary, including physicians' services, hospital care, unspecified "appropriate alternatives" to hospitalization, and prescription drugs. Services that would not have to be covered would include long-term, dental, and vision care; over-the-counter medications; cosmetic surgery; and mental health services, including care for serious mental illness. Based on these specifications, the Actuarial Research Corporation has estimated that the average premium to provide family coverage through such a plan would have been $3,250 in 1991.

The Pauly group does not specify the contents of its proposed minimum benefit plan. At one point it refers to catastrophic coverage, but it then suggests that a starting point for defining the minimum plan could be "the services covered by a low-cost managed-care plan that has achieved a significant market share," which would imply more generous coverage.[1] In any case, the proposal calls for the minimum plan to have lower stop-loss limits for lower-income people, the reasoning being that lower-income people are less able to afford high deductibles and coinsurance payments. This provision would mean that lower-income people would pay greater premiums than higher-income people, other factors being equal. For purposes of comparing the Heritage and Pauly group proposals in this memorandum, CBO has assumed that the minimum benefits plan under the Pauly group proposal would be similar to that proposed by the Heritage Foundation.

Change in Tax Subsidies

Under current law, the principal tax subsidy for health-related expenses goes to people whose employers contribute to their insurance plans. Other health-related subsidies are available to people whose employers contribute to flexible benefit plans and to taxpayers whose medical expenses exceed 7.5 percent of adjusted gross income. Both proposals would replace these subsidies with a subsidy that would depend neither on employment nor on whether a person paid taxes.

Section 106 of the Internal Revenue Code states that employers' contributions to their employees' health insurance premiums are excluded

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1. Mark Pauly and others, *Responsible National Health Insurance* (Washington, D.C.: AEI Press, 1992), p. 13.

from the calculation of employees' taxable income.[2] In 1991, employers spent $192 billion on health insurance, and the value of the tax subsidy was estimated at $46 billion in forgone revenue from income and payroll taxes.[3] Eliminating the tax exclusion would substantially increase the proportion of employees' total compensation that is subject to taxation. It would also make retirees liable for taxes on health insurance premiums paid by their former employers.

Both proposals call for a refundable tax credit to subsidize spending on health care and insurance.[4] The structures of the proposed credits differ, but in both cases the credit is designed to give greater subsidies to lower-income people and to those likely to incur higher expenses for health care and insurance. Unlike the tax exclusion, which subsidizes spending on insurance premiums but not on health care itself, the proposed credits would treat spending on insurance and out-of-pocket care similarly.

So that individuals would not have to wait until they filed their tax returns to receive the subsidy, employees would estimate their expected credit in the same way they now estimate the number of exemptions they will claim. The self-employed would do likewise in computing their estimated tax payments to the Internal Revenue Service. If an individual became unemployed or otherwise underwent a sharp change in circumstances, insurers or health care providers could be required to wait for payment until the credit was processed.

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2. The tax exclusion is analyzed at length in Congressional Budget Office, *The Tax Treatment of Employment-Based Health Insurance* (March 1994).

3. Employer spending estimate from Cathy A. Cowan and Patricia A. McDonnell, "Business, Households, and Governments: Health Spending, 1991," *Health Care Financing Review*, vol. 14, no. 3 (Spring 1993), p. 228. Tax exclusion estimate from Executive Office of the President, *Budget of the United States Government: Fiscal Year 1993* (1992), part 2, p. 27.

   The value of the tax exclusion in fiscal year 1995 is estimated at about $90 billion. See Congressional Budget Office, *Reducing the Deficit: Spending and Revenue Options* (March 1994), p. 311.

4. A tax deduction reduces a person's taxable income, thus reducing his or her tax liability by an amount that depends on the person's marginal tax rate and that is therefore smaller than the size of the deduction. A tax credit reduces tax liability on a dollar-for-dollar basis. A refundable tax credit means that the government refunds money to the individual if the tax credit exceeds the tax liability. For taxation purposes, "total income" is the sum of wages, salaries, taxable interest income, capital gains, alimony received, and similar items. "Adjusted gross income" is total income minus contributions to individual retirement accounts, alimony payments, contributions to Keogh plans, and similar items. "Taxable income" is adjusted gross income minus deductions and the value of exemptions.

The proposals would also repeal two other provisions of current law. Under Section 125 of the tax code, employees enrolled in certain types of flexible benefit plans may use pretax income to pay for premiums, deductibles, coinsurance payments, and other out-of-pocket expenses, although if money set aside in such a plan is not used within a calendar year it is forfeited. Under Section 213, taxpayers whose health expenses exceed 7.5 percent of adjusted gross income may deduct the excess in calculating taxable income.[5]

Change in Federal and State Roles

Both proposals would set nationwide standards for the pricing and marketing of health insurance, an area of regulation that traditionally has been the domain of state governments. Both proposals would also make major changes in the way that the two levels of government share the cost of health programs.

Under current law, the states generally regulate the business of health insurance, which includes regulation of commercial insurers, Blue Cross and Blue Shield plans, and other risk-bearing entities such as health maintenance organizations. State regulation includes limiting the extent to which insurers may charge different policyholders different premiums; requiring insurers to deal with any willing provider; levying taxes on revenue from premiums; setting financial standards to ensure solvency; and mandating insurers to cover specific medical conditions, services, types of people, or types of providers.

In recent years, state legislatures have been very active in defining allowable pricing and marketing practices, particularly for insurance sold to small groups, which typically include 25 to 50 employees, depending on the state. By the end of 1993, 42 states had enacted laws circumscribing insurers' ability to set premiums for small groups.[6] Although a comparable figure is not readily available, insurers traditionally have also been limited in the premiums they could charge for policies bought by individuals. Only in the large-group market are insurers relatively free to set premiums as they see fit.

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5. Two other subsidies expired December 31, 1993. Under one provision, self-employed taxpayers were able to deduct 25 percent of the cost of health insurance; under the other, low-income people eligible for the earned income tax credit could claim a supplementary health insurance credit.

6. Intergovernmental Health Policy Project, The George Washington University, *Health Insurance: Small Groups: An Overview of 1993 State Legislative Activity* (Washington, D.C.: The George Washington University, 1993), pp. 3-6. See also Gretchen Babcock, Susan S. Laudicina, and Brice C. Oakley, *State Legislative Health Care and Insurance Issues* (Washington, D.C.:BlueCross BlueShield Association, December 1993), Appendix.

Employers that bear the financial risk for their employees' health care costs--a practice known as self-insurance--are exempt from state regulation under the federal Employee Retirement Income Security Act of 1974 (ERISA). Although ERISA includes provisions regulating employer health plans, these provisions are generally much less restrictive than state regulation.[7] For example, self-insured firms need not cover specific benefits and need not pay state taxes on premiums.

Under the Heritage proposal, the federal government would set standards for the health insurance industry, particularly with regard to the pricing and marketing of the minimum benefit plan. While states would determine which plans met the federal standards, the federal government could take over that role from states that did not meet their responsibilities. Moreover, state laws would be preempted if they required insurers to cover specific diseases, services, or providers; if they restricted the ability of managed care plans to contract with some providers but not others; or if they restricted insurers' ability to require policyholders to share the cost of their care. Self-insured employers would be subject to the same rules as insurers generally, thus ending their special status under ERISA.

The Pauly group proposal would allow insurers complete freedom from regulation in setting premium rates for new policyholders but would restrict the premiums that they could charge policyholders renewing their coverage. Given the extensive regulation now in place in many states, federal law would have to preempt state laws specifically so that the Pauly group proposal could be put into effect. The proposal also calls for the federal government to preempt all state laws that mandate coverage of specific diseases, services, or providers; as in the Heritage proposal, this preemption would apply to both the minimum benefits and the supplementary plans. Laws that limited the ability of managed care plans to contract with some providers but not others would also be preempted. Self-insured employers would be subject to the same rules regarding solvency and similar matters as insurers are generally.

Proponents of both proposals anticipate that their plans would bring financial benefits to state and local governments. Under either proposal, state and local governments with tax regimes similar to federal law could experience increases in income tax revenues from the elimination of the current tax subsidies. They would also save money if the proposals reduced the amount of uncompensated care that these governments had to pay for.

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7. For a fuller description of the state and federal roles, see Edward F. Shay, "Regulation of Employment-Based Health Benefits: The Intersection of State and Federal Law," in Institute of Medicine, *Employment and Health Benefits: A Connection at Risk* (Washington, D.C.: National Academy Press, 1993).

The Pauly group proposal would also reduce state spending under the Medicaid program, as discussed on page 22.

The Heritage proposal would impose responsibilities on states that would offset at least some of these financial benefits. The federal government's payments for Medicaid acute care services would be capped on a state-by-state basis, so that any state that exceeded its cap would pay the entire excess amount from its own budget. The general approach would be that in fiscal year 1995 each state would be allowed to spend 20 percent more than it did in fiscal year 1993, with increases thereafter allowed at somewhat more than the general inflation rate. Medicaid spending on long-term care would not be affected. Under current law, the federal government shares the cost of each state's Medicaid program in an open-ended fashion. In fiscal year 1991, the federal government spent $52 billion on Medicaid and the states spent $43 billion. Roughly 60 percent of the total was spent on acute care services; a precise breakdown as defined in the Heritage proposal is not readily available and would be subject to data limitations in any case.

The states would also be responsible for identifying uninsured people and arranging coverage for them, either through a state program or through private insurance. States would have to absorb the difference between the cost of coverage and any premiums they were able to collect. States that did not fulfill this role could lose all federal funding for health programs; the proposal does not include intermediate sanctions.

The Heritage Foundation also proposes a new system of federal block grants that the states would use primarily to assist people with incomes below 150 percent of the poverty threshold who were ineligible for Medicaid and whose health expenses exceeded 5 percent of adjusted gross income even after the tax credit was taken into account.[8] States would have wide latitude in providing this aid and could also use the money for preventive and primary care services, to improve emergency medical services systems, and for similarly general purposes. The federal contribution to this new program would be $14.2 billion in fiscal year 1997. This amount equals the Heritage Foundation's estimate of what federal payments would have been to hospitals defined to serve a "disproportionate number of low income patients with special needs"; disproportionate share hospital (DSH) payments under current Medicaid law would be discontinued. Similarly, states would be required to spend about as much on the new program as they otherwise would have spent on DSH payments. In fiscal year 1991, DSH payments were about $9 billion,

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8. The poverty threshold varies with family size. For a three-person family, it was $10,860in 1991, the year used for the numerical illustrations in this memorandum. For this family, income equal to 150 percent of the poverty threshold would be $16,290.

although this number is a rough estimate since specific data on these payments were not collected in that year. In fiscal year 1992, when such data were collected, DSH payments were $17 billion.

The Pauly group says that states could be required to spend as much on health programs as they would have spent under current law, or they could gradually be relieved of such a requirement, or they could be required to contribute an equal portion of income. "Congress's response to these options and the extent to which it requires states to contribute to the health care of their citizens depend upon broader issues of federalism and political balance," the Pauly group states.[9]

Both proposals would leave Medicare enrollees outside the system of tax credits, at least initially. The Heritage proposal notes that the Medicare population could be phased into the system of tax subsidies, possibly by providing enrollees with vouchers they could use to buy a plan. The Pauly group does not refer to vouchers. Instead, it suggests that after some point Medicare would no longer accept new enrollees but it would continue to provide coverage for people already enrolled. As part of funding its proposal, the Heritage Foundation would impose copayments on users of certain Medicare services and make other changes designed to reduce Medicare spending below what it would have been under current law. Analysis of the specific changes is beyond the scope of this memorandum.

DIFFERENCES BETWEEN THE PROPOSALS

The chief differences concern the structure of the proposed tax credit, the specific restrictions that would or would not be placed on insurers' pricing and marketing practices, the role of employers, and the role of the Medicaid program. As noted in the previous subsection, there are also less important differences concerning such features as enforcement of the mandate that individuals have insurance coverage.

Structure of the Tax Credit

The Heritage Foundation's proposed credit would vary with a family's health expenses, while the Pauly group's proposed credit would not. The Pauly group therefore calls its proposed credit a "fixed dollar" credit, although it would be different for different people.

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9. Pauly and others, *Responsible National Health Insurance*, p. 26.

Under the Heritage proposal, the credit would be available to everyone who bought the minimum benefit plan; it would not be available to people covered by Medicare, Medicaid, the military health services system, the Department of Veterans Affairs' medical system, or the Indian Health Service. (The proposal does not say whether people eligible for, say, military health care could choose to forgo that coverage in favor of buying private insurance and receiving the tax credit.) People who had the minimum plan only part of the year (perhaps because they had previously been covered by a public program) would have their credit prorated by the number of entire months in which they had the minimum plan.

A very large part of health spending would be eligible for the credit. "Health expenses" would be defined as the sum of premiums for the minimum benefit plan, premiums for supplementary plans, and eligible out-of-pocket medical expenses. Supplementary plans could provide more generous coverage of services included in the minimum plan or could cover supplementary services such as dental care, vision care, or mental health services, but not long-term care. Eligible out-of-pocket expenses would include deductibles and coinsurance payments as well as out-of-pocket spending on a broad range of health care services, including related transportation services. Over-the-counter medications, long-term care, and cosmetic surgery would be specifically excluded.

The credit would equal 25 percent of that portion of health expenses up to 10 percent of adjusted gross income, plus 50 percent of that portion of expenses between 10 percent and 20 percent of AGI, plus 75 percent of that portion of expenses over 20 percent of AGI. For example, a family with AGI of $30,000 that spent $5,000 for the minimum benefit plan, $700 for a supplementary plan, and $500 in eligible out-of-pocket expenses would receive a credit of $2,400 on its total spending of $6,200.

Taxpayers could also claim a 25 percent nonrefundable credit for contributions to medical savings accounts. An individual could make annual contributions up to $3,000, plus $500 per dependent, to such an account, withdrawing the money in later years to pay health bills. Medical savings accounts are not an essential part of the Heritage proposal, and an analysis of their features and possible effects is beyond the scope of this memorandum.

The Pauly group proposal does not specify who would and would not be eligible for the tax credit, except that Medicare enrollees would be ineligible. A family would receive a credit that would be correlated to its likely use of health care, not its actual use. Unlike the Heritage proposal, there would be no need to define a list of expenses that would count toward the credit.

Calculating the credit for a particular family would be composed of two steps. The base value of the credit would equal the lowest bid made by an insurer for the position of fallback insurer--that is, for the role of covering people who did not choose an insurer. If, for example, the fallback insurer charged $3,000 to provide coverage for a family of average risk, the basic credit would be $3,000. Families of average risk below the poverty threshold would receive $3,000, and the subsidy would decline as income rose until it reached zero at three to five times the threshold. For a particular family, the base value of the credit would then be adjusted to reflect the age, sex, geographic residence, and health status of family members, since these factors are generally correlated with spending on health care.

The proposal does not specify how the adjustments would be made; health status, in particular, can be difficult to quantify and verify. For example, while some insurers might use blood tests and other diagnostic tools to set premiums, it is unlikely that the Internal Revenue Service would collect such information. Therefore, the practicality of the adjustment process cannot be predicted.

The Pauly group also raises the possibility of a supplemental credit available to families whose premiums are more than 50 percent higher than the average for families of the same demographic characteristics. This supplemental credit would be a percentage of the adjusted credit. The group does not elaborate on this suggestion.

Regulation of Pricing and Marketing of Insurance

Under the Heritage proposal, insurers would face tight restrictions on the pricing and marketing of the minimum benefits plan. Under the Pauly group proposal, by contrast, insurers would be allowed broad scope to set premiums and market their plans, at least initially.

Under the Heritage proposal, each insurer would set its own premium schedule for individual and family policies, but premiums could vary only with the age, sex, and geographic residence of the policyholder. Each insurer would have to charge all of its policyholders who have specified demographic characteristics the same premium, regardless of whether they were new or existing policyholders. An important exception is that members of a group could be given discounts to reflect lower marketing and administrative costs. Insurers could also offer discounts designed to promote health, prevent illness, or allow the early detection of illness.

The Heritage proposal would require insurers to accept all applicants and to renew all policies, except in cases of fraud, misrepresentation, or non-payment of premiums. In the year after the proposal would be put in place, no limitations could be placed on coverage of preexisting medical conditions; this provision would encourage people who are now uninsured to seek coverage. After the first year, coverage could be limited for up to one year if the person previously had been uninsured. The states would administer these regulations; for example, they would define the demographic categories that insurers would use and would say what discounts for group purchasing would be allowable.

Under the Pauly group proposal, insurers would be free to set any premiums they wished for new policyholders, at least initially. As a consequence, the proposal anticipates that insurers would make more use of risk rating, in which higher-risk people pay greater premiums than lower-risk people. Aside from age, sex, and geographic residence, insurers could use health status, occupation, or any other factor in evaluating the risk of applicants. The reasoning, the Pauly group states, is that with full risk rating, "insurers have no reason to reject high risks if they can charge an adequate rate and have no incentive to market aggressively to low risks if rates for low risks are bid down to competitive levels."[10] Preexisting medical conditions would have to be covered, but the insurer could charge the corresponding premium.

Although insurers would be free from regulation in setting premiums for new policyholders, they would be restricted in setting premiums for policyholders who renew their coverage. If a policyholder's risk of using health care rose (for example, due to a diagnosis of serious illness), the insurer would have to wait three years before it could increase the premium to reflect the higher risk level. In the interim, premium increases could only reflect broad increases in the cost of providing coverage. (The proposal does not specify how this requirement would be applied to group policies.) The Pauly group's reasoning for this provision is that policyholders should have some protection from being penalized when they become more likely to use insurance; the protection is not extended indefinitely on the grounds it would be infeasible.

Although the Pauly group would allow "full and free risk rating" as outlined above, the proposal also states that more restrictive rules could be put into effect if full risk rating proved impracticable. Restrictions to establish actuarial categories, as in the Heritage proposal, could be introduced

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10. Pauly and others, "A Plan for 'Responsible National Health Insurance'," *Health Affairs*, vol. 10, no. 1 (Spring 1991), p. 15.

if it were true that "high risks still face unacceptably large differences in after-tax premium costs or that administration of risk-related tax credits is difficult."[11]

The Employer Role

Although both proposals would impose some similar requirements on employers, the differences between the proposals are more significant than the similarities. Under both proposals, employers would have to report to the Internal Revenue Service the value of employer-paid premiums for each employee, but how to apportion a group premium to individual group members is not easy to determine. Employers now tend to pay a lump-sum premium to an insurer for an entire group; for example, a company might pay $300,000 to cover 100 employees. The simplest method would be for an employer to apportion the premium equally. In that case, each employee would see a $3,000 increase in taxable income. But an argument can be made that the value of health insurance varies widely among employees; a 60-year-old employee, for example, might have to pay three or four times as much as a 25-year-old if they each bought coverage on their own. Under those circumstances, it could be argued that employer-provided health insurance might be worth $4,800 to the older employee and only $1,200 to the younger employee. Other methods of apportionment are conceivable, such as increasing each employee's taxable income by the same percentage of cash income.

The Heritage proposal would require that the group premium be apportioned using the same categories that insurers would use to set individual premiums: that is, age, sex, and geographic residence. Moreover, employers would be required to pay these amounts in cash to their employees, who could choose to continue their workplace-based plan or to buy coverage elsewhere.

The Pauly group would let each employer decide how to apportion the group premium for tax purposes. Employers would not have to pay out the value of the premium in cash and would not have to give employees a choice of plans. Despite the lack of restrictions, employers would probably tend to apportion the group premium using the same adjustment factors that the government would use to allocate tax credits to individuals. Otherwise, some employees might complain of inequitable treatment. For example, if two employees earn the same salary, and one is in a low-risk category and the other in a high-risk category, and if the group premium were apportioned

11. Pauly and others, *Responsible National Health Insurance*, p. 42.

equally, both employees would see the same increase in tax liability (before the credit was calculated), but the low-risk employee would receive a smaller tax credit than the high-risk employee.

Both proposals would end the distinction between employers whose employees are covered by an insurer and employers that are self-insured. Under the Heritage proposal, self-insured employers would have to cash out their plans, allow their employees to go elsewhere for coverage, and accept applicants from outside at the same premium rates that would apply to employees. Ending the special status of self-insured employers would have fewer consequences under the Pauly group proposal, since that proposal would place fewer requirements on both insurers and employers.

Both proposals would make employers liable for the employer share of the payroll taxes that would be levied on employees' increased income. CBO has not estimated the size of this liability; a study done for the Heritage Foundation estimated it at $7.8 billion in 1991, including the effect of corporate income taxes. Both proposals would try to ensure that employers paid this tax themselves rather than taking it from employees' wages and salaries, at least in the first year. In time, however, CBO would expect employers to reduce wage growth, so that eventually the "employer" share of the payroll tax would be borne by employees because wages would be lower than they would have been otherwise. Even in the transition year, it would be impossible to prevent employers from increasing wages by a smaller amount than they would have if they had not paid a payroll tax.

Both proposals would require employers to cooperate with the government in identifying people who had no insurance and in including the anticipated value of employees' tax credits in their paychecks. Under the Heritage proposal, which specifies that the credit would depend on a year's actual health expenses, estimating the value of the credit would be more difficult than under the Pauly group proposal, which specifies that it would not. Furthermore, the Heritage proposal would require all employers to deduct premiums from paychecks and to forward the premiums to insurers, regardless of whether employees were willing to handle this task themselves.

Medicaid

The Heritage proposal would not change the eligibility rules or benefits of the Medicaid program, while the Pauly group proposal would replace almost all of what are now Medicaid's acute care benefits.

Under the Heritage proposal, current Medicaid beneficiaries would continue to receive benefits from the program. When those people became ineligible for Medicaid, for whatever reason, they would have to buy private insurance and would become eligible for the refundable tax credit. Local welfare offices could verify their income and arrange for their anticipated tax credit to be advanced to them.

Under the Pauly group proposal, Medicaid would no longer cover acute care for beneficiaries under age 65, although it would still cover long-term care. Since only about half the people with income below the poverty threshold now receive Medicaid benefits, the proposal would approximately double the number of people in poverty who would have fully subsidized coverage.[12] The proposal does not offer any further detail on how the minimum benefit plan--which could be less comprehensive than current Medicaid coverage--would replace the program's acute care benefits, especially since these benefits vary considerably among the states. People with fully subsidized coverage would still be responsible for meeting the deductibles and coinsurance requirements of the minimum benefit plan, although their liability would be limited by the requirement that stop-loss limits be lower for lower-income people.

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12. House Committee on Energy and Commerce, Subcommittee on Health and the Environment, *Medicaid Source Book: Background Data and Analysis (A 1993 Update)*, Committee Print 103-A (prepared by the Congressional Research Service, January 1993), p. 3.

CHAPTER III

POTENTIAL IMPLICATIONS OF THE PROPOSALS

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

THE INSURANCE MARKET

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

The Economics of Health Insurance

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

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

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

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

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

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

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

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1. This example reflects cost indexes calculated by the Actuarial Research Corporation and based on data from the 1987 National Medical Expenditure Survey.

2. House Committee on Ways and Means, Subcommittee on Health, *Private Health Insurance: Options for Reform*, Committee Print 101-35 (prepared by the Congressional Research Service, September 1990), p. 12.

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

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

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

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

The Likely Impacts of the Proposals

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Changes in Incentives

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

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

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

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

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

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

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

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

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

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

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

Financial Effects

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

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

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

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

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

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

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

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

Illustrative Examples of Impacts

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

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

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

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

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

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

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

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

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

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

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

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

SOURCE: Congressional Budget Office.

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

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

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

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

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

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

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

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

SOURCE: Congressional Budget Office.

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

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

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

SOURCE: Congressional Budget Office.

a. Assumes that the value of insurance varies with risk level; as well, each family is assumed to pay the same amount ($550) toward its premium.

b. For purposes of this table, the range of premiums is assumed to be the same under both proposals.

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

d. Cannot be estimated from information available.

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

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

HEALTH SPENDING

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

GOVERNMENT FINANCES

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

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

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

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

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

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

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11. This calculation is based on all Medicaid spending, not just that for acute care, and is for fiscal year 1991. Calculated from data in House Committee on Energy and Commerce, Subcommittee on Health and the Environment, *Medicaid Source Book: Background Data and Analysis (A 1993 Update)*, Committee Print 103-A (prepared by the Congressional Research Service, January 1993), pp. 119-20 and 485-86.

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

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

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

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

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

APPENDIX A

SUMMARY OF THE HERITAGE PROPOSAL

The summary of the Heritage proposal that follows was provided by Stuart Butler, Vice President and Director of Domestic and Economic Policy Studies for the Heritage Foundation, in response to a query from the Congressional Budget Office. It is reproduced here verbatim.

The Heritage Foundation

A tax-exempt public policy research institute

April 8, 1994

Dr. Linda Bilheimer
Deputy Assistant Director for Health
Congressional Budget Office
419C Ford House Office Building
Washington, D.C. 20515

Dear Dr. Bilheimer,

As we have discussed by telephone, The Heritage Foundation has changed certain aspects of our Consumer Choice Health Plan since the series of documents we published earlier. In general -- though not in every detail -- these changes are reflected in the relevant parts of the Consumer Choice Health Security Act of 1993, introduced in the Senate by Senator Don Nickles and in the House by Congressman Cliff Stearns. I am pleased to provide in summary form the Heritage proposal as it is today. For your analysis you should assume the Heritage Plan is identical to the relevant Nickles provisions except where noted. There are some differences between the Senate and House versions of the legislation -- confined, I believe, to the Medicare and Medicaid funding provisions. You should take the Senate language as being most similar to our thinking.

Sincerely,

Stuart M. Butler

Stuart Butler, Ph.D.
Vice President
Director of Domestic and Economic
Policy Studies

Implementation

* The proposal would take effect January 1, 1997.

Health Care Expenses Tax Credit

* Anyone covered by a federally qualified health insurance plan would be eligible to receive a refundable tax credit that would depend on the individual's or family's unreimbursed health care expenses as a percentage of adjusted gross income (AGI). These expenses would comprise qualified premiums and eligible medical care expenses. "Federally covered" individuals (see below) would not be eligible for the credit. The credit would be calculated on the following schedule:

  - For that portion of expenses up to 10% of AGI, 25%;
  - For that portion of expenses between 10% and 20% of AGI, 50%;
  - For that portion of expenses exceeding 20% of AGI, 75%.

  For people covered by a federally qualified plan only part of the year, the amount of the credit would be prorated according to the number of whole months in which the individual was covered.

* A 25% credit would be available for contributions to a medical savings account, to be used only for medical purposes. We do not anticipate, at least in the early years after enactment, that a large number of these accounts would be created, and so our calculations of the impact of the plan on specific families assumes a credit is used only for insurance and direct out-of-pocket expenses. Over several years, however, we would expect the number of such accounts to grow.

* All employers would be responsible for advancing to the employee the estimated amount of the employee's health tax credit; all employers would also have to withhold money for the employee's premium and remit it to the plan. Employers who did not comply could be subject to a tax of $50 per day per employee.

  Please note, there is a drafting error in §101(b) of the bill, which specifies that the advance would cover anticipated premiums for the federally qualified health insurance plan, not qualified premiums (which also would

include premiums for supplementary or richer plans). This is unintentional and will be corrected.

* Medical care would be defined broadly to include services related to preventing, diagnosing and treating illness and injury, including related transportation services subject to reasonable limits. Expenses for cosmetic surgery and non-prescription drugs would not count toward the credit. Neither would expenses for the care of dependents be eligible if those expenses were allowable under §21 of the tax code.

* Both premiums paid for the federally qualified plan and for plans that supplemented the federally qualified plan would count in calculating the credit. That is, premiums for supplemental plans or for a plan with more generous coverage than the federal minimum would count if they covered the same set of services as the federally qualified plan. Premiums would not count toward the credit to the extent they covered long-term care. Thus, the intention in The Heritage Plan (and the Nickles bill) is that dental care and dental benefits would be eligible for the credit, but that long-term care (that is, nursing home costs) would not, unless the services qualified as "appropriate alternatives to hospitalization."

Other Health-related Tax Provisions

* The following existing tax provisions would be repealed:

  - The exclusion from taxable income of employer contributions to employees' health insurance plans.

  - The deduction allowed for medical expenses that exceed 7.5% of AGI.

  - The deduction allowed to self-employed people whereby they may deduct 25% of the cost of their health insurance from their total income reported for tax purposes.

  - The earned income tax credit for health insurance.

  - The tax deduction for the self-employed and the health insurance portion of the EITC are both scheduled to expire soon. Both Heritage and the sponsors of the legislation neither propose to extend those provisions beyond their current expiration dates, nor propose to prevent their extension by other legislation up to January 1, 1997, when the new tax credits take effect.

- The tax exclusion for cafeteria-type plans under §125 of the tax code would be changed. Funds for health spending could no longer be included in such tax-free accounts, but instead employees would gain a credit for contributions to their own medical savings account, which would not be subject to the rollover restrictions and other limitations associated with flexible spending accounts or cafeteria plans.

Individual Mandate

* All U.S. citizens and permanent residents would have to be covered by a federally qualified health insurance plan. This requirement would not apply to "federally covered" individuals, who would comprise those covered by Medicare, Medicaid, the military health services system, the Department of Veterans Affairs, and the Indian Health Service.

* States would have the responsibility of identifying residents who refused to purchase the required minimum coverage and enrolling them in a federally qualified plan. (See section on state role below.)

  Please note that we at Heritage have recommended a somewhat different form of enforcement, and in this case "The Heritage Plan" differs from the Nickles-Stearns bill. Under the Nickles Bill, people who did not arrange coverage for themselves--either through the government programs listed above or by buying a federally qualified plan--would be ineligible to claim any exemptions when calculating taxes payable.

  The Heritage proposal does not include the denial of the personal exemption as a penalty for failure to obtain the required minimum coverage. We propose instead that employers be required to report to the state workers who are unable or unwilling to demonstrate proof of minimum coverage for themselves and/or their dependents. This would assist states in identifying such individuals. The sponsors of the legislation did not want to place this burden on employers and instead included the provision denying the personal exemption to those who refuse to purchase coverage.

  In our view, under the legislation, it would still be possible for states to impose a reporting requirement on employers if they so choose.

  Please note there is a drafting error in §103(a)(1) of the bill. As drafted, the bill would inadvertently deny

exemptions to federally covered individuals. This will be corrected.

Federally Qualified Health Insurance Plan

* To be a federally qualified health plan, a plan would have to have at least the following features:

  - Cover all medically necessary acute care services, including at minimum: physician services; inpatient, outpatient, and emergency hospital services; appropriate alternatives to hospitalization; and inpatient and outpatient prescription drugs.

  - Not exclude selected illnesses or selected, medically accepted treatments.

  - Deductible of no more than $1,000 for an individual policy or $2,000 for a family policy, adjusted after 1997 for inflation.

  - "Stop-loss" limit of $5,000 per policy (i.e., same for individual and family policies), adjusted after 1997 for inflation.

* Such a plan would be subject to the following underwriting restrictions:

  - Premiums could vary only with the age, sex, and geographic location of the policyholder.

  - Premiums charged to new and existing policyholders of the same demographic characteristics would have to be identical.

  - Discounts could be given, subject to regulatory approval, if the discounts were designed to promote health, prevent illness, or allow the early detection of illness.

  - Marketing and relating administrative costs would not be considered part of the premium for the purposes of regulatory enforcement of the underwriting and rating restrictions. Thus it would be permissible for an insurer to give "wholesale purchase" discounts to groups of buyers.

  - Guaranteed issue.

  - Guaranteed renewal, except in cases of fraud, misrepresentation, or nonpayment of premiums.

- In 1997, a plan could not limit coverage for pre-existing medical conditions. This is to give the currently uninsured an initial, one-year "window" in which to obtain coverage without regard to their health status. After 1997, a plan could limit coverage of preexisting medical conditions for "X" months, where "X" is the number of months that the applicant was uninsured immediately prior to the date of application. "X" could not exceed 12 months.

- A plan could not offer incentives or disincentives to its agents that encouraged agents to enroll policyholders expected to be relatively low-cost to the plan.

State regulatory authorities would certify which plans were federally qualified. If a state did not meet federal standards for carrying out this certification function, the federal government could take it over for plans in that state.

Transition from Current Insurance Arrangements

* The insurer of a employment-based plan would have to offer existing policyholders (e.g., as of October 1, 1996) the right to convert to a new plan on January 1, 1997. This requirement would apply regardless of whether the plan was self-insured. The new plan would have to offer benefits at least actuarially equivalent to the previous plan, and premiums would have to be set so they varied only with age, sex, and geography. The sum of premiums under the new plan could not exceed the group's total premium on the last day the previous policy was in effect. Insurers who did not comply would be subject to a tax equalling 50% of premium revenue.

  Please note, the bill refers to "employer-sponsored" plans, while at Heritage we use "employment-based" plans as a broader category to also include union-sponsored plans and Taft-Hartley plans. We believe the intention of the Nickles-Stearns legislation is to include such plans as well.

* Any employer sponsoring a self-insured plan that wanted to transfer responsibility for the plan to another party would have to receive the agreement of two-thirds of the plan's primary enrollees. Employers now operating self-insured plans would become subject to all laws pertaining to insurers.

* Each employer now contributing to an employee's health insurance plan would have to "cash out" the plan by increasing each employee's cash wages by an amount in line with the employee's age, sex, and geographic location. Employers who did not comply would be subject to a tax of $50 per day per employee. For federal employees, a commission would be set up to study how to cash out FEHBP benefits and adjust pay scales and retirement benefits accordingly. The reason for this special provision for the FEHBP is that federal pay scales are set by law and congressional action is needed. Further, federal workers with the same base pay may receive different compensation because of the way FEHBP benefits are calculated. The commission's purpose would be to figure out an equitable solution to this special cashing out problem, which would then become an amendment to the law on federal pay.

* Employers could not compel employees to join a plan picked by the employer.

* Each employer would have to hold the employee harmless for the "employer" share of payroll taxes that would become payable on the increase in the employee's taxable income.

State Role

* As a condition of receiving federal funding for health programs, both for entitlement programs and from appropriated funds, states would be responsible for identifying people who were not federally covered and did not purchase a federally qualified health insurance plan. States would have to arrange coverage for these people at least as generous as the federally qualified plan, but could charge premiums that reflected the cost of coverage and the individual's ability to pay. States could meet this responsibility through a new program or through an existing program such as Medicaid.

* States would set up a new program designed to assist people with incomes below 150% of poverty who were ineligible for Medicaid, were eligible for the health tax credit, and for whom premiums and medical expenses exceeded 5% of AGI even after the tax credit was taken into account. States could use funds in this program to assist eligible individuals with supplemental vouchers for purchasing health insurance or by paying for services such as primary and preventive care, emergency transportation, trauma care systems, operating clinics and so forth. Federal funding for the new program would roughly equal expected federal contributions under the Medicaid program to "disproportionate share hospitals" (DSH); the DSH program would be repealed. The federal government would transfer $14.2 billion to the

states in the 1997 fiscal year, with the state-by-state allocation depending on each state's share of the needy population, as defined. States would maintain current efforts through matching payments to the new program.

Please note, based on preliminary estimates, we expect these funds would permit states to reduce direct health spending by members of the target population to about 10% of gross income. We expect that states would in most cases provide assistance in the form of a supplemental voucher, although it could be in other forms, such as free or subsidized clinics.

* State laws would be preempted if they:

  - required health insurance policies to cover specific diseases, services, or providers; or
  - restricted the ability of managed care plans to selectively contract with providers or to impose different levels of cost-sharing on enrollee claims for treatment by providers outside the plan; or
  - restricted insurers' ability to require cost-sharing.

Financing

Please note that at Heritage we are not explicitly wedded to a particular method of financing the difference between the cost of the new tax credit and low income subsidy and the value of the existing tax exclusion. But we are comfortable with the method used in the Nickles bill, as set out below. The House version, as I noted earlier, differs slightly from the Senate measure.

* In addition to the increased revenues that would result from repealing the tax provisions discussed above and from repealing Medicaid DSH payments, the proposal also includes revenue-raising measures affecting the Medicare and Medicaid programs.

* The growth in Medicare spending would be less than it otherwise would have been, due to such measures as eliminating Medicare DSH payments; reducing the adjustment for indirect medical education; imposing copayments on laboratory services, certain home health visits, and skilled nursing facility services; shifting hospital payment updates to January from October; and accelerating the transition to prospective rates for facility costs on outpatient services.

* In a major change for the Medicaid program, the federal contribution to the acute care portion of the program would be capped, with the federal government also easing the requirements for states to receive waivers to establish

innovative and cost-effective programs. The effect of this provision would be to recoup to the federal government most, but not all, of the savings and revenue increases that would accrue to the states under the plan.

* Neither our plan nor the Nickles bill would affect Medicaid long term care.

APPENDIX B

ALTERNATIVE ILLUSTRATIONS OF FINANCIAL IMPACTS

The discussion on pages 36-42, which illustrates the possible financial impacts on various types of families, assumed that under current law each family had the same level of out-of-pocket spending on health care. This assumption was made in order to focus attention on the different impacts that the two proposals would have on families in different situations. In fact, however, out-of-pocket spending varies systematically with variables such as income, insurance coverage, and health status. This appendix therefore provides the interested reader with illustrations that are perhaps more realistic than those in the text, albeit at the cost of increased complexity in the numbers. Regardless of which tables are considered, the qualitative comments made in the text hold true.

The out-of-pocket spending estimates under current law that are shown in Tables B-1 to B-3 reflect CBO's tabulations of data from the 1987 National Medical Expenditure Survey. Most estimates were averages for families of at least three members, all of whom were under 65 years old and had private insurance throughout the year. Families were grouped by income and relative risk, with risk groups defined using the survey's questions on health status as proxies for risk level. Those families reporting good or excellent health status for all members were grouped as "lower risk"; those families in which any member reported poor health status were "higher risk"; and all other cases, including families who reported fair health status, were classified as "average risk." Furthermore, Table B-2 includes an estimate that reflects average out-of-pocket spending by all families that were without insurance during the year, were in the middle-income and average-risk groups, and had no members 65 years old or older. Since the survey reflected 1987 spending patterns, the estimates were inflated to 1991 dollars using the growth in out-of-pocket spending per person from the national health accounts.

The change in out-of-pocket spending under either proposal is very difficult to predict, especially at the level of detail shown in the tables. Accordingly, these tables arbitrarily follow the tables in the text by assuming that spending on out-of-pocket care and supplementary premiums would be 45 percent higher if the proposals were implemented than under current law. The only exception is the uninsured family shown in Table B-2; since it is

uninsured under current law and would have insurance with a high deductible in these illustrations under either proposal, its out-of-pocket spending is shown as unchanging.

TABLE B-1. ALTERNATIVE ILLUSTRATION OF POSSIBLE IMPACTS OF PROPOSALS, BY INCOME OF FAMILY (In dollars)

	Income		
	Lower	Middle	Higher
Current Law			
Income Reported for Tax Purposes	21,000	38,000	55,000
Plus nontaxable premiums	3,140	3,140	3,140
Less income and payroll taxes	-2,940	-6,790	-11,690
Less total premium	-3,690	-3,690	-3,690
Less out-of-pocket spending	-830	-900	-1,910
Equals total compensation less taxes and health expenses	16,680	29,760	40,850
Heritage Proposal			
Income Reported for Tax Purposes	24,140	41,140	58,140
Less income and payroll taxes	-3,640	-7,490	-12,610
Less total premium	-3,250	-3,250	-3,250
Less out-of-pocket spending and supplementary premiums	-1,200	-1,310	-2,770
Plus health tax credit	1,630	1,250	1,560
Equals total compensation less taxes and health expenses	17,680	30,340	41,070
Difference from Current Law	1,000	580	220
Pauly Group Proposal			
Income Reported for Tax Purposes	24,140	41,140	58,140
Less income and payroll taxes	-3,640	-7,490	-12,610
Less total premium	-3,250	-3,250	-3,250
Less out-of-pocket spending and supplementary premiums	-1,200	-1,310	-2,770
Plus health tax credit	2,080	910	0
Equals total compensation less taxes and health expenses	18,130	30,000	39,510
Difference from Current Law	1,450	240	-1,340

SOURCE: Congressional Budget Office.

TABLE B-2. ALTERNATIVE ILLUSTRATION OF POSSIBLE IMPACTS OF PROPOSALS, BY CURRENT INSURANCE STATUS OF FAMILY (In dollars)

	Employer Purchase	Individual Purchase	Uninsured
Current Law			
Income Reported for Tax Purposes	38,000	38,000	38,000
Plus nontaxable premiums	3,140	0	0
Less income and payroll taxes	-6,790	-6,360	-6,790
Less total premium	-3,690	-4,780	0
Less out-of-pocket spending	-900	-900	-1,010
Equals total compensation less taxes and health expenses	29,760	25,960	30,200
Heritage Proposal			
Income Reported for Tax Purposes	41,140	38,000	38,000
Less income and payroll taxes	-7,490	-6,790	-6,790
Less total premium	-3,250	-3,250	-3,250
Less out-of-pocket spending and supplementary premiums	-1,310	-1,310	-1,010
Plus health tax credit	1,250	1,330	1,180
Equals total compensation less taxes and health expenses	30,340	27,980	28,130
Difference from Current Law	580	2,020	-2,070
Pauly Group Proposal			
Income Reported for Tax Purposes	41,140	38,000	38,000
Less income and payroll taxes	-7,490	-6,790	-6,790
Less total premium	-3,250	-3,250	-3,250
Less out-of-pocket spending and supplementary premiums	-1,310	-1,310	-1,010
Plus health tax credit	910	1,130	1,130
Equals total compensation less taxes and health expenses	30,000	27,780	28,080
Difference from Current Law	240	1,820	-2,120

SOURCE: Congressional Budget Office.

TABLE B-3. ALTERNATIVE ILLUSTRATION OF POSSIBLE IMPACTS OF PROPOSALS, BY RELATIVE RISK LEVEL OF FAMILY (In dollars)

	Relative Risk Level		
	Low	Average	High
Current Law			
Income Reported for Tax Purposes	38,000	38,000	38,000
Plus nontaxable premiums[a]	1,860	3,140	4,440
Less income and payroll taxes	-6,790	-6,790	-6,790
Less total premium[a]	-2,410	-3,690	-4,990
Less out-of-pocket spending	-1,040	-900	-1,370
Equals total compensation less taxes and health expenses	29,620	29,760	29,290
Heritage Proposal			
Income Reported for Tax Purposes	39,860	41,140	42,440
Less income and payroll taxes	-7,200	-7,490	-7,790
Less total premium[b]	-2,120	-3,250	-4,390
Less out-of-pocket spending and supplementary premiums	-1,500	-1,310	-1,980
Plus health tax credit	900	1,250	2,130
Equals total compensation less taxes and health expenses	29,940	30,340	30,410
Difference from Current Law	320	580	1,120
Pauly Group Proposal			
Income Reported for Tax Purposes	39,860	41,140	42,440
Less income and payroll taxes	-7,200	-7,490	-7,790
Less total premium[b]	-2,120	-3,250	-4,390
Less out-of-pocket spending and supplementary premiums	-1,500	-1,310	-1,980
Plus health tax credit	c	910	c
Equals total compensation less taxes and health expenses	c	30,000	c
Difference from Current Law	c	240	c

SOURCE: Congressional Budget Office.

a. Assumes that the value of insurance varies with risk level; as well, each family is assumed to pay the same amount ($550) toward its premium.

b. For purposes of this table, the range of premiums is assumed to be the same under both proposals.

c. Cannot be estimated from information available.