A PRELIMINARY ANALYSIS OF THE HEALTH SECURITY ACT AS REPORTED BY THE SENATE COMMITTEE ON FINANCE

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The Congress of the United States
Congressional Budget Office

INTRODUCTION

The Congressional Budget Office (CBO) and the Joint Committee on Taxation (JCT) have prepared this preliminary analysis of the Health Security Act, as ordered reported by the Senate Committee on Finance on July 2, 1994. The analysis is based on the description of the Chairman's mark of June 28, the errata sheet of June 29, the amendments adopted during the Committee's markup, and information provided by the Committee's staff. Although CBO and JCT have worked closely with the staff of the Committee, the estimate does not reflect detailed specifications for all provisions or final legislative language and must therefore be regarded as preliminary.

The first part of the analysis is a review of the financial impact of the proposal. The financial analysis includes estimates of the proposal's effects on the federal budget, the budgets of state and local governments, health insurance coverage, and national health expenditures. The analysis also includes a description of the major assumptions that CBO has made affecting the estimate.

The second part of the analysis comprises a brief assessment of considerations arising from the proposal's design that could affect its implementation. The issues examined in this discussion are similar to those considered in Chapters 4 and 5 of CBO's analyses of the Administration's health proposal and the Managed Competition Act.

FINANCIAL IMPACT OF THE PROPOSAL

The Health Security Act, as ordered reported by the Senate Committee on Finance, aims to increase health insurance coverage by reforming the market for health insurance and by subsidizing its purchase. In the Congressional Budget Office's estimation, the proposal would add about 20 million people to the insurance rolls, and the number of uninsured would drop to 8 percent of the population. Initially, the proposal would add to national health expenditures, but by 2004 national health expenditures would be slightly below the baseline. Over the period from 1995 to 2004, the proposal would slightly reduce the federal budget deficit, and it would ultimately reduce state and local government spending as well.

The estimated effects of the proposal are displayed in the four tables at the end of this document. Table 1 shows the effect on federal outlays, revenues, and the deficit. Table 2 shows the effects on the budgets of state and local governments. Tables 3 and 4 provide projections of health insurance coverage and national health expenditures, respectively.

Like the estimates of other proposals for comprehensive reform--such as the single-payer plan, the Administration's proposal, the Managed Competition Act, and the bill reported by the Committee on Ways and Means--CBO's estimates of

the effects of this proposal are unavoidably uncertain. Nonetheless, the estimates provide useful comparative information on the relative costs and savings of the different proposals. In estimating the Finance Committee's proposal, CBO and JCT have made the following major assumptions about its provisions.[1]

Health Insurance Benefits and Premiums

The Finance Committee's proposal would establish a standard package of health insurance benefits, whose actuarial value would be based on that of the Blue Cross/Blue Shield Standard Option under the Federal Employees Health Benefits program. The Congressional Research Service and CBO estimate that such a benefit package would initially be 3 percent less costly than the average benefit of privately insured people today and 8 percent less costly than the benefit package in the Administration's proposal.

The proposal adopts the four basic types of health insurance units included in the Administration's proposal--single adult, married couple, one-parent family, and two-parent family. In general, workers in firms with fewer than 100 employees (and their dependents) and people in families with no connection to the labor force would purchase health insurance in a community-rated market. Firms employing 100 or more workers would be experience-rated. The estimated average premiums in 1994 for the standard benefit package for the four types of policies are as follows:

	Community-Rated Pool	Experience-Rated Pool
Single Adult	$2,330	$2,065
Married Couple	$4,660	$4,130
One-Parent Family	$4,544	$4,027
Two-Parent Family	$6,175	$5,472

In addition, separate policies would be available for children eligible for subsidies, as explained below. Supplementary insurance would be available to cover cost-sharing amounts and services not included in the standard benefit package.

1. For descriptions of CBO's estimating methodology, see Congressional Budget Office, *An Analysis of the Administration's Health Proposal* (February 1994), and *An Analysis of the Managed Competition Act* (April 1994).

Subsidies

The proposal would establish a system of premium subsidies for low-income people to encourage the purchase of health insurance. Families with income below 100 percent of the poverty level would be eligible for full subsidies, and those with income between 100 percent and 200 percent of poverty would be eligible for partial subsidies. The partial subsidies would be phased in between 1997 and 2000 by gradually increasing the income eligibility level. In addition, children and pregnant women with income up to 240 percent of the poverty level would be eligible for special subsidies.

In determining eligibility for premium subsidies, a family's income would be compared with the federal poverty threshold for that family's size, except that the threshold would be the same for families with four or more members. The estimate assumes that this limitation would apply for computing both regular subsidies and the special subsidies for children and pregnant women.

The maximum amount of the subsidy would be based on family income relative to the poverty level and on the weighted average premium for community-rated health plans in the area. The estimate assumes that a family's subsidy could not exceed the amount it paid for coverage in a qualified health plan. Therefore, if an employer paid a portion of the premium, the subsidy could at most equal the family's portion of the premium. The estimate also assumes that, except in 1997, the same formula would be used in each year to compute the amount of the subsidy, but that during the phase-in period no subsidies would be available to people above the applicable eligibility level.

Families would not be eligible, the estimate assumes, for both regular premium subsidies and special subsidies for children and pregnant women, but they could choose to receive the larger one. Families could use the special subsidies to help purchase coverage for the entire family, or they could purchase coverage only for the eligible children and pregnant women.

Families, children, and pregnant women with income below the poverty threshold would also be eligible for reduced cost sharing, as determined by the National Health Benefits Board. The estimate assumes that the board would require nominal cost-sharing payments. Health insurance plans would be required to absorb the cost of this reduced cost sharing. In addition, states would have the option of providing subsidies for cost sharing for people with income between 100 percent and 200 percent of the poverty level. The federal government would pay up to $2 billion a year to assist the states in providing these optional cost-sharing subsidies, and states would have to pay the rest of the cost.

The system of subsidies would be administered by the states. States would have the option of providing subsidies to eligible people beginning in 1996 and would be required to provide subsidies starting in 1997. Because of the difficulties involved in setting up the necessary administrative apparatus, the estimate assumes that states would not begin paying subsidies until 1997.

Medicaid and Medicare

Medicaid beneficiaries not receiving Supplemental Security Income would be integrated into the general program of health care reform and would be eligible for federal subsidies in the same way as other low-income people. Medicaid would continue to provide these beneficiaries with a wraparound benefit covering certain health care services not included in the standard benefit package. States would be relieved of their portion of Medicaid costs for these beneficiaries but would be required to make maintenance-of-effort payments to the federal government. The estimate assumes that these maintenance-of-effort payments would equal the appropriate portion of the states' Medicaid spending in 1994, increased in subsequent years by the rate of growth of national health expenditures plus an adjustment factor. The adjustment factor would equal 1 percentage point through 1997 and would be gradually reduced to zero by 2002.

The proposal would gradually phase out federal Medicaid payments to disproportionate share hospitals (DSHs). The estimate assumes that DSH payments would be limited to 10 percent of medical assistance payments in 1997, 8 percent in 1998, 6 percent in 1999, and 4 percent in 2000. In 2001, DSH payments would be repealed and would be replaced by a program to make payments to vulnerable hospitals. That program would have an annual appropriation of $2.5 billion.

Among the proposed changes in Medicare is a revision in the method of reimbursing Medicare risk contractors. The estimate assumes that this provision is intended to even out reimbursement rates without adding to total costs.

Revenues

The Committee's amendment that added the special subsidies for children and pregnant women also provided that the cost of these subsides would be covered by proportional increases in all of the revenue-raising measures in the proposal, as needed to keep the proposal from adding to the deficit. The estimate includes additional revenues of $13.6 billion over the 1996-2001 period as a result of this provision.

Fail-Safe Mechanism

In the present estimates, the fail-safe mechanism would not be called into play. If necessary, however, the proposal would scale back eligibility for premium and cost-sharing assistance, reduce the new tax deductions, and increase the out-of-pocket limits in the standard benefit package to prevent the proposal from adding to the deficit over a period of years. The deficit would be allowed to increase in any one year, however, but by no more than the amount of any cumulative savings from previous years.

Unforeseen circumstances--such as a major recession, an acceleration in the growth of health care costs, or a more rapid increase in the number of Medicare or Medicaid beneficiaries--could create a shortfall in funding and trigger the fail-safe mechanism. Although the proposal would give the Administration some flexibility in offsetting any unfinanced health spending, the bulk of any savings would have to come from limiting eligibility for subsidies. As a result, application of the fail-safe mechanism could make previously eligible people ineligible for subsidies and would reduce the extent of health insurance coverage.

OTHER CONSIDERATIONS

Like other fundamental reform proposals, the plan reported by the Senate Committee on Finance would require many changes in the current system of health insurance. For the proposed system to function effectively, new data would have to be collected, new procedures and adjustment mechanisms developed, and new institutions and administrative capabilities created. In preparing the quantitative estimates presented in this assessment, the Congressional Budget Office has assumed not only that all those things could be done but also that they could be accomplished in the time frame laid out in the proposal.

In CBO's judgment, however, there exists a significant chance that the substantial changes required by this proposal--and by other systemic reform proposals--could not be achieved as assumed. The following discussion summarizes the major areas of possible difficulty as well as some other possible consequences of the proposal.

Risk Adjustment

The proposal, like most others, assumes that an effective system could be designed and implemented to adjust health plans' premiums for the actuarial risk of their enrollees. In fact, the feasibility of developing and successfully implementing such a mechanism in the foreseeable future is highly uncertain. Inadequate risk-

adjustment techniques would have adverse consequences for both the community-rated and the experience-rated health insurance markets.

The primary purpose of the risk-adjustment system in the community-rated market would be to redistribute premium payments among health plans, compensating them for differences in risk. Without effective risk adjustment, the profitability of health plans in those markets would be partly determined by the plans' skill in attracting relatively healthy people. Since high-cost plans would be subject to a premium tax under this proposal, an effective risk adjustment would also be important to ensure that health plans were not taxed because their enrollees presented a higher risk.

While there would be no risk-adjustment payments in the experience-rated market, each plan that was not self-insured would have to have a risk-adjustment factor in order to determine whether it was liable for the tax on high-cost plans. Developing such factors would be extraordinarily difficult because the agency responsible for doing that would have to collect and analyze significant amounts of information from the many health plans, some of which would be very small, that made up the experience-rated market.

States' Responsibilities

Virtually all proposals to restructure the health care system incorporate major additional administrative, monitoring, and oversight functions that some new or existing agencies or organizations would have to undertake. A key question with any proposal is whether the designated organizations would have the appropriate capabilities and resources to perform their roles. In the Senate Finance Committee's proposal, states would bear the brunt of many of the responsibilities for implementation, and it is uncertain whether--and, if so, how soon--some states would be ready to assume them.

The states' primary responsibilities under the proposal would fall into four broad areas:

- determining eligibility for the new subsidies and the continuing Medicaid program;
- administering the subsidy and Medicaid programs;
- establishing the infrastructure for the effective functioning of health care markets; and
- regulating and monitoring the health insurance industry.

Determining Eligibility for Subsidies and Medicaid. The task of establishing and monitoring eligibility for subsidies would be an enormous one for states, even without the complications resulting from the dual structure that would subsidize premiums using two sets of rules (discussed in more detail below). According to CBO's estimates, in the year 2000, about 30 million families and single individuals would be receiving subsidies for health insurance premiums at any time. The actual number of applications would be much greater than that because of changes in employment, family status, or geographic location during the year. In addition, because Medicaid would be required to provide wraparound benefits, states would have to continue to operate their Medicaid eligibility systems using income criteria for families with more than four members that were different from the criteria used by the premium subsidy program.

States would also bear the responsibility for the required end-of-year reconciliation process in which the income of a subsidized family was checked to ensure that the family received the appropriate premium subsidy. Reconciliation would be a major undertaking since, although federal income tax information could be used, many of the families receiving subsidies would not be tax filers. Moreover, the process would require extensive interstate cooperation in order to track people who moved from one state to another during the year.

Administering the Subsidy and Medicaid Programs. The states would have other major administrative responsibilities for the subsidy and Medicaid programs. In particular, they would make subsidy payments to health plans and engage in outreach efforts to encourage enrollment of the low-income population. Health plans would be required to have an open-enrollment period of 90 days during the first year and only 30 days in all subsequent years. Establishing effective outreach programs would therefore be essential to ensure that low-income people enrolled in health plans during the open-enrollment window.

The optional programs in which states could participate would also have major administrative components. States electing to subsidize cost sharing for people with income between 100 percent and 200 percent of the poverty level would be responsible for administering those subsidies. Similarly, states would have to administer the complex system of subsidies incorporated in the proposal if they chose to expand home- and community-based services for the disabled. States could also choose to enroll beneficiaries of the Supplemental Security Income program in health plans, in which case they would have to negotiate separate premiums.

Establishing the Infrastructure for the Effective Functioning of Health Care Markets. States would be required to designate the geographic boundaries for the community-rating areas as well as the service areas for implementing the provisions regarding essential community providers. The liability for the tax on

high-cost community-rated and experience-rated plans would be calculated separately for each community-rating area. In addition, states would have to sponsor or establish purchasing cooperatives to serve those community-rating areas in which none were established voluntarily.

States would also have ongoing responsibilities for ensuring that health care markets functioned effectively. Those responsibilities would include establishing the system for adjusting premiums for risk, operating reinsurance pools until the risk-adjustment system was operating effectively, and redistributing losses resulting from the requirement that plans absorb the cost-sharing expenses for people with income below the poverty threshold.

Providing consumers with the necessary information to make informed choices among health plans would be another function of the states. States would be required to produce annual, standardized information comparing the performance of health plans in each community-rating area; they would also distribute that information, educate and provide outreach to consumers, and respond to complaints from consumers. To do all that effectively would require that states establish extensive systems for reporting and analyzing data and qualitative information. They would also be responsible for ensuring that health plans met federal standards for data reporting.

Regulating and Monitoring the Health Insurance Industry. The responsibilities for certifying insured health plans, self-insured plans that operated in one state only, and insurance plans for long-term care would all fall on the states. So too would the task of enforcing the new health insurance standards. Consequently, the duties of state insurance departments would grow considerably. Not only would they be responsible for many more health plans than they oversee today, but the activities they would have to monitor would be much more extensive. States would be encouraged to use private accreditation organizations to assist them with these tasks.

States would, moreover, be required to act in the event that health plans did not meet federal standards. For example, they might have to operate failed or noncompliant health plans for a transitional period to ensure continued access for the plans' enrollees, develop corrective programs, or design other options.

States would have to develop and implement programs to recover payment from automobile insurers for medical services resulting from automobile accidents. These programs would be required to have electronic data bases and include mechanisms for resolving liability issues or disputes rapidly.

At present, state insurance departments vary widely in their capabilities. It seems doubtful, therefore, that all of them would be ready for such an expanded role by 1997.

The Dual System of Subsidies

The proposal includes two subsidy schedules--one for low-income families and the other for low-income children and pregnant women. The two subsidy schemes would have to be integrated because children and pregnant women are a part of families; but integrating them in a sensible and administrable fashion would be extremely difficult. As now structured, the dual system of subsidies would create a confusing array of options from which low-income families would have to choose, would greatly complicate state administration of the already burdensome processes for determining eligibility and reconciling subsidies at year-end, and could result in real or perceived inequities in the treatment of low-income families.

In making its estimates, CBO assumed that no family could participate in both subsidy schemes at the same time but that families could choose whichever scheme gave them the larger subsidy. Permitting families to participate in both programs concurrently--for example, by obtaining special subsidies for the children individually as well as regular subsidies for single or dual policies for the parents --could cause the estimated cost of the subsidies to be somewhat higher than that shown in Table 1.

Insurance Costs for Moderate-Sized Firms

As is the case under other proposals that limit participation in the community-rated market to small firms and nonworkers, some moderate-sized firms--those with 100 to 300 or 400 employees--might face relatively high costs for coverage under the Senate Finance Committee's proposal. Just as they do under the current system, such firms would have to either self-insure or offer coverage through the experience-rated market. Moreover, they would be required to provide their employees with a choice of three plans, including a fee-for-service plan. Thus, the enrollment in some of those plans could be extremely small, especially since some employees in families with two workers could obtain their coverage elsewhere.

Small enrollments would, in turn, result in high administrative costs. Furthermore, because the firm's premiums would be experience-rated, a single employee with a costly medical problem could raise the firm's premiums significantly. Some plans could end up with ever-increasing premiums and

shrinking enrollment as people who could obtain cheaper coverage through their spouse's employer left the plan, raising its premiums further. At a minimum, employees would no longer have a realistic choice of three plans, and in extreme cases, all three plans might be quite expensive. In principle, individuals with income below the poverty level enrolled in such plans would be fully subsidized, but in fact they might have to contribute to the costs of their coverage if the premiums for all three plans were above the average for the community-rated market, which determines the maximum possible subsidy.

Tax on High-Cost Health Plans

The proposed tax on high-cost health plans would be difficult to implement. It would, moreover, result in different effective tax rates on excess premiums of the health plans offered by different insurers or sponsors. These differences might be viewed as arbitrary because they would vary significantly within and among community-rating areas.

The tax would be imposed at a 25 percent rate on the amount by which high-cost premiums exceeded a target premium set for each community-rating area. Various adjustments would be made to premiums to determine which plans would be classified as having high costs. Those adjustments would be difficult to make. Moreover, some of the necessary adjustments--such as those for differences in risk and the cost of living among geographic areas--would require data and methodologies that do not now exist.

The effective tax rate on excess premiums would generally be much higher than the statutory rate of 25 percent for two reasons. First, unlike most other excise taxes, this one would not be a deductible expense for health plans and self-insured employers; in effect, the tax would be paid from after-tax, rather than before-tax, profits. Second, if insurers that expected to be subject to the tax increased their premiums to reflect the additional tax liability, both their excise tax and income tax liabilities would also rise. As a result, the effective tax rate on excess health insurance premiums would not be 25 percent but 62.5 percent for most plans offered by taxable insurers and 33 percent for nontaxable (nonprofit) insurers. Self-insured employers who reduced other compensation to offset their higher expenses for health benefits would face an effective tax rate of 38.5 percent if they were taxable corporations and 25 percent if they were nontaxable sponsors of a health plan.

Although the tax would provide incentives for insurers to offer lower-cost plans, how insurers would actually respond is unclear. Because the calculation of the tax would be based on the combined cost of standard and supplemental policies, insurers might, for example, try to discourage enrollees from purchasing

supplements by raising those premiums considerably. Alternatively, they might not offer supplemental policies at all. A more fundamental problem for insurers is that they would not know the target premium--and, hence, their potential tax liability--at the time they established their premiums because those targets would be announced 90 days after the end of each open-enrollment period. That uncertainty would tend to increase the margins between insurance premiums and expected payouts as insurers attempted to protect themselves from the possibility that their plan would be considered a high-cost plan and thus subject to the tax.

The tax might be considered inequitable for a variety of reasons. In some community-rating areas, a small number of health plans--perhaps two or three--might dominate the market. Using the criterion that high-cost plans covered 40 percent of the primary insured population in an area could necessitate highly arbitrary decisions in the face of such indivisibilities. (For example, the highest-priced plan might cover 20 percent of the primary insured population while the top two plans covered 60 percent.) In the experience-rated market--if accurate risk-adjustment factors cannot be developed--small plans with little ability to control their premiums might well be the ones subject to the tax. Finally, plans in some areas of the country with low payments to providers and parsimonious practice patterns might be subject to the tax even though they were far less costly (even after the required adjustments) than nontaxed plans in other areas. This result could occur in spite of the fact that plans with adjusted premiums in the lowest quartile nationwide would not be subject to the tax.

Reallocation of Workers Among Firms

The proposal would encourage a reallocation of workers among firms and, in doing so, would increase its budgetary cost. This sorting would occur because the subsidies could be reduced by up to the amount that employers contributed for insurance; therefore, a worker employed by a firm that paid for health insurance would receive a smaller subsidy than a worker at a firm that did not pay. Some low-income workers could gain thousands of dollars in higher wages by moving to firms that did not contribute to employee health insurance, and a significant number of them would probably do so. That process would occur gradually as employment expanded in some firms and contracted in others. In the CBO estimate, this reallocation of low-wage workers among firms accounts for $12.6 billion of the cost of the subsidies in 2004.

In addition, some companies might stop paying for insurance, but the effect of that action on the government's costs would probably not be large, for several reasons. For one thing, the number of firms that would be likely to stop paying is limited because, if firms did so, high-wage workers in those firms would lose the tax benefits of excluding health insurance from the payroll tax. Moreover, the

net additional subsidy cost to the government from low-income workers in firms that dropped coverage would be largely offset by higher tax revenues from the workers because, without employer-paid coverage, wages would be higher.

Last, reducing subsidies by up to the amount that employers pay for insurance would mean that people with similar incomes and family circumstances would not be treated alike. In particular, workers at firms that paid for insurance would face larger costs for their insurance than similarly placed counterparts at firms that did not pay.

Work Disincentives

Like other reform plans with substantial subsidies, the Senate Finance Committee's proposal would discourage certain low-income people from working more hours or, in some cases, from working at all, because subsidies would be phased out as family income increased. For example, the subsidies for low-income families would be phased out as family income rose between 100 percent and 200 percent of the poverty threshold, and those for low-income children and pregnant women would be phased out between 185 percent and 240 percent of poverty. In both cases, many workers who earned more money within the phaseout range would have to pay more for their own or their children's health insurance, thereby cutting into the increase in their take-home wage. In essence, phasing out the subsidies would implicitly tax their income from work.

Estimating the precise magnitude of the implicit tax rates requires information that is not readily available, but rough calculations suggest that the rates could be substantial. In 2000, for example, the effective marginal levy on labor compensation could increase by as much as 30 to 45 percentage points for workers in families eligible for low-income subsidies and 20 to 40 percentage points for workers in families choosing the subsidies for pregnant women and low-income children. Moreover, those levies would be piled on top of the explicit and implicit marginal taxes that such workers already pay through the income tax, the payroll tax, the phaseout of the earned income tax credit, and the loss of eligibility for food stamps. In the end, some low-wage workers would keep as little as 10 cents of every additional dollar they earned.

If the employer did not pay for insurance, the implicit marginal rates from the phaseout of low-income subsidies would apply to workers whose income was within the broad range of 100 percent to 200 percent of the poverty level. But if the employer paid some of the costs for insurance, these marginal levies would apply to workers in a much smaller income range. Although this treatment of employer payments would reduce the size of the working population affected by higher marginal levies, it would create the previously described incentive for workers to move to firms that did not pay for insurance.

TABLE 1. PRELIMINARY ESTIMATES OF THE FEDERAL BUDGETARY EFFECTS OF THE HEALTH SECURITY ACT AS REPORTED BY THE COMMITTEE ON FINANCE

(By fiscal year, in billions of dollars)

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
MANDATORY OUTLAYS										
Medicaid										
1 Discontinued Coverage of Acute Care	0	0	-24.6	-36.7	-41.0	-45.8	-51.2	-56.9	-63.1	-69.7
2 State Maintenance-of-Effort Payments	0	0	-16.8	-24.0	-26.2	-28.4	-30.8	-33.4	-36.2	-39.2
3 Disproportionate Share Hospital Payments	0	0	-4.1	-7.0	-9.5	-11.6	-18.8	-20.7	-22.9	-25.2
4 Long Term Care Program/Change Fed Match	2.5	2.8	3.1	3.5	3.9	4.4	4.9	5.5	6.1	6.9
5 Administrative Savings	0	0	-0.3	-0.5	-0.5	-0.6	-0.7	-0.8	-0.8	-0.9
Total - Medicaid	2.5	2.8	-42.7	-64.7	-73.3	-82.0	-96.6	-106.3	-116.9	-128.1
Medicare										
6 Part A Reductions										
PPS Updates	0	0	-0.8	-2.3	-4.2	-6.4	-7.1	-8.1	-8.9	-9.8
Capital Reduction	0	-0.7	-0.8	-0.8	-0.9	-1.0	-1.2	-1.3	-1.4	-1.6
Disproportionate Share Hospital Reductions	0	0	0	-0.9	-1.2	-1.3	-1.4	-1.5	-1.7	-1.9
PPS-Excluded Payment Changes	0.1	0.1	0.2	0.2	0.2	0.2	0.2	0.3	0.3	0.3
Skilled Nursing Facility Limits	0	-0.1	-0.1	-0.2	-0.2	-0.2	-0.2	-0.2	-0.3	-0.3
Sole Community Hospitals	a	a	a	a	a	a	a	a	a	a
Medicare Dependent Hospitals	a	0.1	0.1	0.1	a	a	0.0	0.0	0.0	0.0
Long Term Care Hospitals	a	a	-0.1	-0.1	-0.1	-0.2	-0.2	-0.3	-0.3	-0.4
7 Essential Access Community Hospitals										
MAF Payments	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
Rural Primary Care Hospitals (RPCH) Pmts	0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.2	0.2	0.2
8 Part B Reductions										
Updates for Physician Services	-0.4	-0.6	-0.6	-0.7	-0.8	-0.8	-0.9	-1.0	-1.0	-1.1
Real GDP for Volume and Intensity	0	0	-0.3	-0.8	-1.6	-2.5	-3.3	-4.2	-5.3	-6.6
High Cost Hospitals	0	0	0	-0.5	-0.8	-0.8	-0.8	-0.9	-1.0	-1.0
Elim Formula Driven Overpayments	-0.5	-1.0	-1.3	-1.8	-2.3	-3.2	-4.2	-5.5	-7.1	-9.1
Eye & Eye/Ear Specialty Hospitals	a	a	a	0	0	0	0	0	0	0
Laboratory Coinsurance	-0.7	-1.1	-1.3	-1.4	-1.6	-1.8	-2.0	-2.3	-2.6	-2.9
Competitive Bid for Part B	a	-0.1	-0.1	-0.1	-0.1	-0.2	-0.2	-0.2	-0.2	-0.2
Competitive Bid for Clinical Lab Services	a	-0.2	-0.3	-0.3	-0.3	-0.4	-0.4	-0.5	-0.5	-0.6
Nurse Pract/Phys Assistant Direct Payment	0	0	0.1	0.2	0.2	0.3	0.3	0.4	0.5	0.6
Permanent Extension of 25% Part B Premium	0	0.6	0.9	1.4	0.8	-0.8	-2.8	-5.2	-8.2	-10.6
9 Parts A and B Reductions										
Medicare Secondary Payer	0	0	0	0	-1.2	-1.8	-1.9	-2.0	-2.2	-2.3
Expand Centers of Excellence	0	-0.1	-0.1	-0.1	-0.1	-0.1	a	a	0	0
Home Health Limits	0	0	-0.3	-0.6	-0.7	-0.7	-0.8	-0.9	-1.0	-1.0
Risk Contracts	a	0.1	0.2	0.2	0.3	0.3	0.4	0.4	0.5	0.6
Total - Medicare	-1.3	-2.9	-4.5	-8.6	-14.5	-21.0	-26.3	-32.8	-40.0	-47.4

Continued

TABLE 1. Continued

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Other Health Programs										
10 Vulnerable Hospital Payments	0	0	0	0	0	0	2.5	2.5	2.5	2.5
11 Home and Community Based Care Program	0	0	0.3	0.7	1.0	1.4	1.6	1.7	1.9	2.0
12 Academic Health Centers Trust Fund	0	4.7	7.0	8.0	9.1	10.3	11.3	12.3	13.3	14.3
13 Grad Medical & Nursing Education Trust Fund	0	2.7	4.0	5.8	6.9	7.6	8.2	8.9	9.6	10.4
14 Medicare Transfer - Graduate Medical Education	0	-1.6	-2.2	-2.4	-2.5	-2.6	-2.8	-2.9	-3.1	-3.3
15 Medicare Transfer - Indirect Medical Education	0	-4.2	-4.5	-4.9	-5.4	-5.9	-6.5	-7.2	-7.9	-8.7
Total - Other Health Programs	0	1.6	4.6	7.2	9.1	10.8	14.3	15.3	16.3	17.2
Designated Urban/ Rural Health Care Access										
16 Investment in Infrastructure Development (Loans	0.3	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.5
Total - Urban/Rural Access	0.3	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.5
Subsidies										
Premium Subsidies:										
17 Persons between 0-200% of Poverty	0	0	52.4	86.2	97.6	109.3	121.0	133.6	147.3	161.2
18 Pregnant Women and Kids 0-240% of Poverty				---------- Included in Line 17 ----------						
Cost-Sharing Subsidies:										
19 Persons between 0-200% of Poverty b/	0	0	1.3	2.0	2.0	2.0	2.0	2.0	2.0	2.0
Total - Subsidies	0	0	53.7	88.2	99.6	111.3	123.0	135.6	149.3	163.2
Administrative Expenses										
20 Mandatory Administrative Expenses c/	0	0	2.4	4.0	4.3	4.7	4.8	4.9	4.9	5.0
MANDATORY OUTLAY CHANGES	1.4	1.8	13.9	26.5	25.5	24.2	19.6	17.2	14.0	10.4
DISCRETIONARY OUTLAYS										
Administrative Expenses										
21 Administrative and Start-Up Costs	0.5	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.1
Studies, Research, & Demonstrations										
22 Network and Plan Development Grant Program	0.1	0.2	0.3	0.3	0.3	0.2	0.2	0.2	0.2	0.3
23 Operating Asst - Telemedicine Demonstrations	0.1	0.3	0.4	0.4	0.4	0.4	0.4	0.5	0.5	0.5

Continued

TABLE 1. Continued

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
24 Capital Investment - Grants	0.1	0.3	0.3	0.4	0.4	0.4	0.4	0.4	0.4	0.4
25 Biomedical & Behavioral Research Trust Fund	0	0.7	1.2	1.4	1.5	1.6	1.7	1.9	2.1	2.2
26 EACH/MAF/Rural Transition Demonstrations	a	0.1	0.1	0.1	a	a	a	a	a	a
Total Studies, Research, & Demonstrations	0.4	1.6	2.3	2.5	2.5	2.6	2.7	3.0	3.2	3.4
DISCRETIONARY OUTLAY CHANGES	0.9	2.6	3.3	3.5	3.5	3.6	3.7	4.0	4.2	4.5
TOTAL OUTLAY CHANGES	**2.3**	**4.4**	**17.1**	**30.0**	**29.0**	**27.7**	**23.3**	**21.2**	**18.2**	**14.9**
RECEIPTS										
27 Increase in Tax on Tobacco Products	13.9	16.3	15.4	15.0	14.3	13.9	13.5	11.3	11.1	10.9
28 1.75% Excise Tax on Pvt Health Ins Premiums	0	3.5	6.2	7.2	7.8	8.5	9.2	10.0	10.9	11.8
29 Addl Medicare Part B Premiums for High-Income Individuals	0	0	1.5	1.3	1.6	2.1	2.6	3.4	4.3	5.5
30 Increase Excise Tax on Hollow-Point Bullets	---------- Negligible Revenue Loss ----------									
31 Include Certain Svc-Reln Income in SECA and Excl Certain Invn-Reln Income from SECA										
a) General Fund Effect	0	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1
b) OASDI Effect	0	0.1	0.2	0.2	0.2	0.3	0.3	0.3	0.3	0.3
32 Extend Medicare Coverage & HI Tax to All State and Local Government Employees	0	1.6	1.6	1.5	1.5	1.4	1.4	1.3	1.2	1.2
33 Impose Excise Tax with Respect to Plans Failing to Satisfy Voluntary Contribution Rule	0	a	a	a	a	a	a	a	a	a
34 Repeal Flexible Spending Arrangements	0	0.3	0.5	0.7	1.1	1.3	1.4	1.4	1.4	1.5
35 Extend 25% Ded for Health Ins Costs of Self-Employed Individuals	-0.5	-0.3	0	0	0	0	0	0	0	0
36 Limit on Prepayment of Medical Premiums	---------- Negligible Revenue Gain ----------									
37 Deduct for Individuals Purchasing Own Health In	0	-1.4	-5.5	-8.1	-8.4	-8.7	-9.1	-9.8	-10.4	-11.0
38 Non-Profit Health Care Orgns/Taxable Orgns Providing Health Ins & Prepd Health Care Sv	---------- Negligible Revenue Effect ----------									
39 Trmt of Certain Ins Co with Regard to Sect 833	---------- Negligible Revenue Effect ----------									
40 Grant Tax Exempt Status to State Ins Risk Pools	a	a	0	0	0	0	0	0	0	0
41 Remove $150 million Bond Cap on Non-Hospital 501(c)(3) Bonds	a	a	a	-0.1	-0.1	-0.1	-0.1	-0.2	-0.2	-0.2
42 Clarify Tax Trmt of Long Term care Ins & Svcs	0	a	-0.2	-0.2	-0.2	-0.2	-0.3	-0.3	-0.3	-0.4
43 Tax Trmt of Accelerated Death Benefits Under Life Insurance Contracts	a	a	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1
44 Incr in Reporting Penalties for Nonemployees	0	a	a	a	a	a	a	a	a	a

Continued

TABLE 1. Continued

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
45 Post-Retirement Med & Life Ins Reserves			---------- Negligible Revenue Effect ----------							
46 Modify COBRA Continuation Care Rules			---------- Negligible Revenue Effect ----------							
47 Tax Credit for Practitioners in Underserved Area	a	-0.1	-0.2	-0.2	-0.2	-0.1	-0.1	a	a	a
48 Increase Expensing Limit for Certain Med Equip	a	a	a	a	a	a	a	a	a	a
49 Tax Credit for Cost of Personal Asst Svcs Required by Employed Individuals	0	a	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.2	-0.2
50 Disclosure of Return Info to State Agencies			---------- No Revenue Effect ----------							
51 Exempt Doctors from Section 457 Limits	a	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1
52 Impose Prem Tax with Respect to Certain High Cost Plans	0	a	0.9	1.4	1.6	1.7	1.9	1.8	1.9	2.0
53 Indirect Tax Effects of Changes in Tax Trmt of Employer & Household Health Ins Spending	0	a	1.2	1.4	1.4	1.4	1.4	1.6	1.6	1.5
TOTAL RECEIPT CHANGES	13.3	19.8	21.3	19.8	20.3	21.1	21.8	20.3	21.3	22.6
DEFICIT										
MANDATORY CHANGES	**-11.9**	**-18.0**	**-7.4**	**6.7**	**5.2**	**3.1**	**-2.2**	**-3.1**	**-7.3**	**-12.2**
TOTAL CHANGES	**-11.0**	**-15.4**	**-4.2**	**10.2**	**8.7**	**6.6**	**1.5**	**0.9**	**-3.1**	**-7.7**
CUMULATIVE DEFICIT EFFECT	**-11.0**	**-26.4**	**-30.6**	**-20.3**	**-11.6**	**-5.0**	**-3.4**	**-2.6**	**-5.6**	**-13.3**

SOURCES: Congressional Budget Office; Joint Committee on Taxation

NOTES:

The figures in this table include changes in authorizations of appropriations and in Social Security that would not be counted for pay-as-you-go scoring under the Budget Enforcement Act of 1990.

Provisions with no cost have been excluded from this table.

a. Less than $50 million.

b. The states would have the option to provide funding for cost-sharing subsidies for persons below 200% of poverty.

c. States would have substantial administrative responsibilities under this plan.

TABLE 2. PRELIMINARY ESTIMATES OF THE STATE AND LOCAL BUDGETARY EFFECTS OF THE HEALTH SECURITY ACT AS REPORTED BY THE COMMITTEE ON FINANCE

(By fiscal year, in billions of dollars)

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Medicaid										
1 Discontinued Coverage of Acute Care	0	0	-18.4	-27.5	-30.7	-34.3	-38.4	-42.7	-47.3	-52.3
2 State Maintenance-of-Effort Payments	0	0	16.8	24.0	26.2	28.4	30.8	33.4	36.2	39.2
3 Disproportionate Share and Vulnerable Hospital Payments a/	0	0	0.5	0.9	1.2	1.4	-0.2	0.0	0.3	0.6
4 Administrative Savings	0	0	-0.2	-0.4	-0.4	-0.5	-0.5	-0.6	-0.6	-0.7
Total - Medicaid	0	0	-1.3	-3.0	-3.7	-5.0	-8.3	-9.9	-11.4	-13.2
Cost-Sharing Subsidies:										
5 Persons between 0-200% of Poverty b/	0	0	1.3	2.0	2.0	2.0	2.0	2.0	2.0	2.0
Total - Subsidies	0	0	1.3	2.0	2.0	2.0	2.0	2.0	2.0	2.0
Administrative Expenses										
6 Expenses Associated with Subsidies	0	0	0.8	1.2	1.3	1.5	1.5	1.5	1.5	1.6
7 General Admin and Start Up Costs	0	1.4	2.2	2.4	2.4	2.5	2.7	2.8	3.0	3.2
8 Automobile Insurance Coordination	0	0.3	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
Total - Administrative Expenses	0	1.7	3.0	3.7	3.9	4.1	4.3	4.5	4.7	4.9
Total State and Local Budgetary Impact	**0**	**1.7**	**3.0**	**2.7**	**2.1**	**1.1**	**-2.0**	**-3.4**	**-4.7**	**-6.2**

SOURCE: Congressional Budget Office.

a. The estimate assumes that states will continue to provide some assistance to hospitals serving disproportionately large numbers of uninsured or underinsured people.

b. The states would have the option to provide funding for cost-sharing subsidies for persons below 200% of poverty.

Table 3. Health Insurance Coverage
(By calendar year, in millions of people)

	1997	1998	1999	2000	2001	2002	2003	2004
				Baseline				
Insured	224	226	228	229	230	232	233	234
Uninsured	40	40	40	41	42	43	43	44
Total	264	266	268	270	272	274	276	278
Uninsured as Percentage of Total	15	15	15	15	15	16	16	16
	Health Security Act as Reported by the Committee on Finance							
Insured	241	244	246	249	251	253	255	257
Uninsured	23	22	22	21	21	21	21	21
Total	264	266	268	270	272	274	276	278
Increase in Insured	16	18	19	20	20	21	22	23
Uninsured as Percentage of Total	9	8	8	8	8	8	8	8

SOURCE: Congressional Budget Office.

Table 4. Projections of National Health Expenditures (By calendar year, in billions of dollars)

	1997	1998	1999	2000	2001	2002	2003	2004
Baseline	1,263	1,372	1,488	1,613	1,748	1,894	2,052	2,220
Health Security Act as Reported by the Committee on Finance	1,297	1,403	1,515	1,635	1,761	1,903	2,055	2,218
Change from Baseline	34	32	27	21	13	9	3	−2

SOURCE: Congressional Budget Office.