AN ANALYSIS OF THE BIPARTISAN HEALTH CARE REFORM ACT

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INTRODUCTION

The Congressional Budget Office (CBO) and the Joint Committee on Taxation have prepared this analysis of the Bipartisan Health Care Reform Act of 1994--a proposal developed by a group of Members of the House of Representatives from both political parties. The analysis is based on the text of the proposal as printed on August 10 and on subsequent revisions specified by the group's staff. It comprises a review of the financial impact of the proposal and a brief assessment of its economic effects and other factors that could affect its implementation.

FINANCIAL IMPACT OF THE PROPOSAL

The bipartisan proposal would increase access to private health insurance through reforming the marketplace and providing financial incentives to purchase insurance. Employers would be required to offer a choice of health plans to their employees, but they would not be required to pay for health insurance. The federal government would subsidize the purchase of health insurance for low-income people, and Medicaid beneficiaries who do not receive Medicare or Supplemental Security Income (SSI) would be integrated into the program of low-income subsidies. The proposal would also make health insurance premiums fully deductible for people who are self-employed and partly deductible for others who do not have an employer's contribution for health insurance. The net cost of the subsidies would be paid for largely by reductions in Medicare and by the savings from integrating many Medicaid beneficiaries into the new program.

The estimated federal budgetary effects of the bipartisan proposal are displayed in Table 1 at the end of this document. Tables 2, 3, and 4 show its effects on the budgets of state and local governments, health insurance coverage, and national health expenditures, respectively. CBO estimates that the proposal would eventually extend health insurance coverage to 92 percent of the population. National health expenditures would rise slightly, but the federal deficit would be somewhat lower.

Measures to Reform the Market for Private Health Insurance

The proposal would require employers to offer each employee a choice of health plans, if available in the local market. That choice would have to include at least two standard plans, one of which did not limit the choice of providers, and a high-deductible (catastrophic) plan. A standard plan would have to offer benefits whose actuarial value equaled that of the Blue Cross/Blue Shield standard option under the Federal Employees Health Benefits (FEHB) program. The Congressional Research Service and CBO estimate that such a benefit package would initially be 3 percent less costly than the average benefit package of privately insured people today. The actuarial value of the catastrophic plan would be 80 percent of that of a standard plan.

In addition, employers could offer other benefit packages as long as their actuarial value exceeded that of the catastrophic plan. Although the proposal would not require a uniform package of benefits, all plans would have to provide benefits that equaled or exceeded the narrowest scope and shortest duration of any service or benefit offered by any FEHB plan in 1994. Supplementary policies would be available to cover cost-sharing amounts and additional services.

Individuals and firms with fewer than 100 workers would purchase insurance in the community-rated market in which they were located. Within this market, the premium rates established by an insurer could not vary within each type of plan except by age group, family type, or administrative category. Firms employing 100 or more workers would be experience-rated. The proposal adopts the four basic types of health insurance units included in the Administration's health proposal--single adult, married couple, one-parent family, and two-parent family. In addition, separate policies would be available for children eligible for special subsidies, as explained below. The estimated average premiums in 1994 for standard plans for the four types of policies are as follows:

	Community-Rated Pool	Experience-Rated Pool
Single Adult	$2,183	$2,083
Married Couple	$4,366	$4,166
One-Parent Family	$4,256	$4,062
Two-Parent Family	$5,784	$5,520

CBO estimates that about 80 million people, or one-third of the nonelderly population, would be included in the community-rated pool.

Insurance companies that offered plans in the individual and small-group market would be required to sell coverage to all individuals and small employers, provide for an annual period of open enrollment, and limit exclusions for preexisting conditions. The Secretary of Health and Human Services (HHS) would ask the National Association of Insurance Commissioners (NAIC) to develop models of risk-adjustment mechanisms to even out risks among insurance plans in this market and to discourage insurers from seeking to insure only low-cost people. States would be required to implement a risk-adjustment system that conforms with one of the models. Most of these same requirements would apply to fully insured multiple-employer welfare arrangements (MEWAs) that furnish insurance to small employers. They would also apply to small-employer pooling arrangements (SEPAs)--MEWAs that are not fully insured and in which more than 10 percent of the participants are small employers.

The proposal would encourage states to establish health plan purchasing organizations (HPPOs), which would market competing health insurance plans in the individual and small-group market. States would not be required to establish HPPOs, however, and insurance carriers would not be required to participate in them. The proposal would preempt many state laws mandating benefits or restricting managed care. It would alter the system of medical malpractice liability by limiting awards for noneconomic damages, establishing a uniform statute of limitations, and requiring that claims be subject to nonbinding arbitration before a civil suit could be filed.

Subsidies

The bipartisan proposal would establish a program to subsidize health insurance premiums and provide cost-sharing assistance for low-income people not receiving Medicare or SSI. States would determine eligibility for subsidies and distribute subsidy payments to health plans.

Premium subsidies would be phased in over the period from 1998 through 2004 by gradually increasing the maximum income level for eligibility. Families with income below 100 percent of the poverty level would be eligible for full subsidies; when the subsidies were fully phased in, families with income between 100 percent and 200 percent of poverty would be eligible for partial subsidies. For children and pregnant women, full subsidies would extend to 185 percent of the poverty level and partial subsidies to 240 percent of poverty. Families could be eligible for more than one type of subsidy at the same time. They could use the subsidies for children and pregnant women to help purchase coverage for the entire family, or they could purchase coverage only for the eligible individuals.

In determining eligibility for premium subsidies, a family's income would be compared with the federal poverty level for that family's size, except that the threshold would be the same for families with four or more members. The maximum amount of the subsidy would be based on family income relative to the poverty level and on the weighted average premium for qualified standard community-rated health plans in the local rating area. 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. People eligible for a full subsidy could use the subsidy only to purchase a standard policy; people eligible for a partial subsidy could purchase a catastrophic policy, but only if they demonstrated that they had sufficient liquid assets to meet the deductible.

People with income below 100 percent of the poverty level would also be eligible for subsidies that would reduce their cost-sharing requirements to nominal amounts. CBO assumed that those amounts would be similar to the levels typically faced by

enrollees in managed care plans. Thus, cost-sharing subsidies would be paid primarily to people enrolled in traditional indemnity plans with relatively high cost-sharing requirements.

Medicare and Medicaid

Medicaid beneficiaries not receiving SSI or Medicare would be integrated into the general program of low-income subsidies. Supplemental coverage would continue for acute care benefits that were generally not included in standard health plans, but the growth of federal payments for supplemental benefits would be limited to the growth of FEHB premiums plus the growth of the eligible population. States would be required to make maintenance-of-effort expenditures based on the amount by which their Medicaid spending was reduced. The proposal would also reduce the limit on Medicaid payments to disproportionate share hospitals by 25 percent in 1995 through 1998, 30 percent in 1999 and 2000, 35 percent in 2001 and 2002, and 37 percent in 2003 and thereafter.

Reductions in Medicare spending and increases in Medicare premiums would provide a major part of the funding for the proposal. The growth in reimbursement rates for hospitals covered by Medicare's prospective payment system would be reduced by 2 percentage points each year from 1997 through 2000, and payments for capital-related costs for inpatient hospital services would also be cut. Reimbursements to physicians and other providers of health care services would be restrained.

Beneficiaries would be required to pay higher premiums for Supplementary Medical Insurance (SMI) and part of the cost of laboratory services. The provision of law setting the basic SMI premium at 25 percent of program costs would be made permanent after its currently scheduled expiration at the end of 1998. SMI enrollees with income above a threshold amount ($75,000 for single taxpayers and $100,000 for married taxpayers filing a joint return) would pay a higher percentage of program costs; this income-related premium would be collected through the income tax system.

Other Spending

The proposal would also make several other, smaller changes in federal spending. The federal government would pay half of the costs that states incur in administering the subsidy program and the full cost of other new administrative requirements. Substantial expansions would be made in several discretionary programs of the Public Health Service. Outlays for Social Security retirement benefits would increase slightly because the assurance of access to health insurance and the provision of subsidies to

low-income families would encourage some workers aged 62 to 64 to retire earlier. The availability of subsidies for private health insurance would reduce the demand for veterans' medical care. And the Postal Service would be required to prefund the health benefits of its annuitants.

Tax Deductibility of Health Insurance

Until 1994, self-employed people were allowed to deduct 25 percent of their health insurance costs from income for income tax purposes. The proposal would allow them to deduct 25 percent of their health insurance premiums in 1994 through 1998, 50 percent in 1999, and 100 percent in 2000 and thereafter. Other people who were not eligible to participate in a health plan with an employer contribution would be permitted to deduct 25 percent of health insurance premiums starting in 1996. The Joint Committee on Taxation estimates that these provisions would reduce revenues by $33 billion over the 1995-2004 period.

The bipartisan proposal would also restrict the use of cafeteria plans and flexible spending arrangements to provide health benefits. Cafeteria plans could not be used to pay for more than 20 percent of health insurance premiums or for any supplementary insurance to cover cost-sharing requirements. In addition, when making contributions for health insurance, employers could not discriminate against workers who would be eligible for subsidies. Together, these provisions would limit the ability of employers to change the form of a worker's compensation for the purpose of maximizing federal subsidy payments.

Tax Treatment of Medical Savings Accounts and Long-Term Care Insurance

The proposal would create new tax benefits for medical savings accounts (MSAs) and long-term care insurance. In general, employees enrolled in catastrophic plans would be eligible for an MSA, but recipients of Aid to Families with Dependent Children (AFDC) or Supplemental Security Income and other people with income less than 100 percent of poverty would be ineligible. Also, catastrophic policies would be available only to employees who could demonstrate that they had liquid assets equal to the deductible amount. Employers' contributions to MSAs would be excludable from employees' income for tax purposes, provided that the annual contribution did not exceed the difference between the premiums for standard and catastrophic coverage. Withdrawals from MSAs would be excluded from taxable income if they were used to pay qualified medical expenses, but withdrawals for any other use before age 65 would be subject to income tax plus a penalty of 100 percent of the amount withdrawn. Interest earned on balances in an MSA would be taxable.

The Secretary of HHS, in conjunction with the NAIC, would develop standards for policies for long-term care insurance. Qualified policies would be treated as health insurance for tax purposes. Employer contributions and benefits would be excluded from income for tax purposes, and premium payments and other expenses for care would be deductible to the extent that total out-of-pocket medical expenses exceeded 7.5 percent of adjusted gross income. Deductible expenses would include long-term care expenses for a parent or grandparent who was not a dependent of the taxpayer. In addition, proceeds from life insurance policies would not be taxable if used to pay premiums for qualified long-term care insurance. The estimate assumes that long-term care insurance could not be offered through a cafeteria plan.

Fail-Safe Mechanism

The proposal would scale back the amounts available for supplemental acute care benefits and for premium subsidies if federal spending for Medicare, Medicaid, and the new subsidy program threatened to exceed the initial estimate. Spending for supplemental benefits would be reduced first; then, if any excess spending remained, premium subsidies would be cut. The subsidies would not be reduced, however, for people with income below 100 percent of poverty. Any reduction in premium subsidies as a result of applying the fail-safe mechanism would reduce the extent of health insurance coverage.

OTHER CONSIDERATIONS

The House bipartisan proposal to restructure the health care system, like others, would require widespread changes in the current system of health insurance. Many of the details of those changes would be determined after the proposal was enacted and would be based on the recommendations and decisions of the National Association of Insurance Commissioners, a new Health Quality Advisory Council, and existing federal agencies. Nonetheless, this proposal would maintain considerable flexibility for health insurers, potentially complicating the difficult task of rationalizing and simplifying health insurance markets. In addition, like several other proposals, this one would establish a complex system of subsidies and place considerable demands on the states.

CBO's estimates assume that the proposal could be implemented successfully within the intended time frame. In fact, however, there is a significant chance that the substantial changes required by this and other systemic reform proposals could not be achieved as assumed. The following discussion summarizes the major areas of potential difficulty as well as some other possible consequences of the proposal.

Adverse Selection and Risk Adjustment

As with other health care proposals, effective mechanisms for adjusting premiums among health insurers to reflect the actuarial risk of their enrollees would be essential for the community-rated markets to function appropriately. The development and implementation of reliable risk-adjustment mechanisms is likely to remain an elusive goal, however, at least in the immediate future. Risk adjustment involves separating the effects of variations in the health status of enrollees from other factors that cause health plans' costs and utilization patterns to differ--such as cost-sharing arrangements, patient management techniques, and differences in the proclivities of enrollees to use health services. That process would be particularly complex if health plans could provide different benefits and have a variety of cost-sharing arrangements, as they could under the bipartisan proposal. Moreover, by providing opportunities and incentives for people to sort themselves among plans according to their health risks and preference for medical care, such variations among health plans would increase the need for accurate risk adjustment.

Under this proposal, the actuarial value of qualified health plans--those that could be offered by employers or through HPPOs--could vary over a 20 percent range, from catastrophic coverage at the low end to standard coverage at the high end. Regardless of their actuarial values, qualified health plans would have to meet the same minimum benefit requirements, but coverage of specific services could differ. Insurers could sell supplementary policies to cover additional benefits and cost-sharing amounts; they could also sell plans--which could not be offered by employers or through HPPOs--with actuarial values below that of catastrophic plans.

The net effect of these provisions on premiums in community-rated markets is uncertain. Some people would probably choose coverage with a lower actuarial value than that of standard plans. People who did so would generally be healthier and use fewer health services on average than those who selected standard coverage. Without effective risk adjustment, therefore, premiums for standard plans would tend to rise relative to those of other plans. Because people receiving full subsidies for premiums would be required to enroll in standard plans, subsidy costs would increase correspondingly.

The proposal would place some limits on the amount of adverse selection that might otherwise occur. It would do so by requiring premiums for different types of coverage to be based on the actuarial value of the coverage for a standardized population. But the variation in benefits could make that a difficult requirement to enforce. Moreover, carriers could still experience adverse selection since the distribution of their enrollees among plans of different types would vary. Carriers that concentrated more on the catastrophic end of the insurance spectrum would probably enroll people whose overall average risk status was lower than that of the people

enrolled by carriers that specialized in providing comprehensive coverage. Consequently, risk adjustment would still be necessary to ensure that carriers enrolling populations with an above-average risk status were not at a financial disadvantage.

Although the continuation of multiple-employer pooling arrangements (SEPAs and fully insured MEWAs) could also raise premiums in the community-rated market (by providing the means for small firms with relatively healthy employees to opt out of the market), the proposal would place several requirements on such arrangements to minimize any adverse consequences. SEPAs would have to meet certification standards established by the Secretary of Labor. Fully insured MEWAs would have to abide by the same fair-rating practice standards as other community-rated plans. Both types of arrangements would have to participate in the risk-adjustment processes in community-rated markets and meet the associated reporting requirements of the states. (In the case of SEPAs, reinsurance and stop-loss carriers would also have to participate in the risk-adjustment process.) The level of premiums in community-rated markets would depend on how successful the federal and state governments were in designing workable risk-adjustment systems and in implementing these provisions.

Insurance Costs for Moderate-Sized Firms

Like several other recent health care proposals, this one would restrict participation in the community-rated market to individuals and to firms with fewer than 100 employees. Larger firms would have to either self-insure or offer experience-rated coverage obtained from an insurance carrier. Moderate-sized firms--those with 100 to 300 employees--might face relatively high premiums under this structure, not only because they would be experience-rated but also because of the requirement to offer their employees a choice of at least two standard benefit plans and a catastrophic plan.

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 result in high administrative costs; they would also mean that one employee with a costly medical problem could raise a plan's premiums significantly. Some plans could end up with increasing premiums and shrinking enrollment as employees either switched to cheaper plans offered by the firm or joined plans offered by their spouse's employer. At a minimum, employees would no longer have a choice of three reasonably priced plans, and in extreme cases, all three plans might be quite expensive.

Cost Containment

The House bipartisan proposal, like several other recent proposals, includes few provisions that would improve the competitiveness of health care markets or reduce the rate of growth of health spending. The proposal would not, for example, tie the amount of the tax subsidy for health insurance to the price of a lower-cost or average-cost plan; people selecting the most costly plans would receive full tax subsidies as they do under current law. Similarly, people receiving full premium and cost-sharing subsidies would have little incentive to enroll in lower-cost plans. By not requiring states to establish purchasing cooperatives, the proposal provides no guarantee that community-rated firms and individuals would have access to the reduced administrative costs and increased purchasing power that such cooperatives would provide. Consumers' ability to make informed choices could also be limited by the lack of a single source of standardized information on all health plans available in each community-rating area. The lack of incentives to contain costs would cause premiums to continue to rise at baseline rates, producing corresponding increases in the cost of subsidies.

Effects of the Proposal on the Medicare Program

Any proposal such as this one, which would be financed by cuts in the Medicare program and would do little to contain private spending on health care, raises some concerns about the sustainability of the Medicare reductions. Relative to the rates of private payers, Medicare's payment rates would probably fall slightly more under this proposal than under proposals that reduced the rate of growth of private-sector costs. Growing disparities in rates between Medicare and the private sector could impair the access of Medicare beneficiaries to health care.

Although access for Medicare beneficiaries has not, apparently, been adversely affected by the drop in Medicare's payment rates (relative to those of private payers) that has occurred since the mid-1980s, there is probably some point at which access would be threatened. If access for Medicare beneficiaries was appreciably reduced, the Congress would probably be compelled to liberalize payments, thereby eliminating some of the estimated savings for Medicare.

The Dual System of Subsidies

Following the pattern established by other recent health care proposals, this one incorporates two subsidy systems with different eligibility criteria: a regular scheme of subsidies for low-income families and a system of special subsidies--with more generous income eligibility criteria--for children and pregnant women. The special

subsidies would provide coverage to a large, vulnerable population and, in the case of children, would do so relatively inexpensively. In addition, those subsidies would ensure that most of the people with income above the poverty level who would be eligible for Medicaid under current law would continue to have insurance when their Medicaid coverage was terminated.

Integrating the regular and special subsidies in a sensible and administrable fashion would be difficult, however, especially because some families would be eligible to receive subsidies from both programs. The complexities would be compounded during the phase-in period (1998-2004), when the income eligibility for regular subsidies would be changing each year. (By contrast, the ceiling on income eligibility for the special subsidies would be fixed at 185 percent of the poverty level through 2002 and then rise to 240 percent of the poverty level by 2004.)

States' Responsibilities

Most proposals to restructure the health care system incorporate major additional administrative and regulatory functions that new or existing agencies or organizations would have to undertake. Like several other proposals, this one would place significant responsibility on the states for developing and implementing the new system, and it is doubtful that all the states would be ready to assume their new responsibilities in the time frame envisioned.

Establishing eligibility for subsidies and administering the subsidy programs would be major tasks for the states--tasks made more complicated by the dual system of subsidies. States would have to estimate the weighted average premium in each community-rated market to establish the subsidy amounts for which people would be eligible. They would be required to issue vouchers for premiums and (in the case of poor families) for cost sharing and to redeem those vouchers when health plans submitted them for payment. States would also bear the responsibility for the end-of-year reconciliation process in which the income of a subsidized family would be checked to ensure that the family received the appropriate premium subsidy. Reconciliation would be a formidable undertaking since even if federal tax information could be used, many of the families receiving subsidies would not be tax filers. Tracking people who moved from one state to another during the year would also be difficult and would require extensive cooperation among the states. Since the subsidy program would not begin until 1998, however, states would have a longer time to prepare for these responsibilities under the bipartisan proposal than they would under some other proposals.

In addition to the subsidy programs, states would be required to establish and administer programs for the provision of supplemental acute care benefits. Those

programs would commence in 1995--three years before the subsidy programs--and would initially provide services to AFDC beneficiaries and to other Medicaid enrollees who do not receive cash benefits, replacing part of the current Medicaid program. Beginning in 1998, supplemental benefit programs would provide services to people eligible for premium subsidies.

States would have considerable flexibility in developing supplemental benefit programs, which would have to be coordinated with other federal programs serving the target populations and with qualified health plans. States would be expected to submit plans to the Secretary of Health and Human Services describing the benefits offered by their programs and indicating how they would assure access, quality, and coordination.

The primary responsibility for implementing reforms in the health insurance market would also fall on the states. They would define community-rating areas and establish risk-adjustment mechanisms within those areas, using risk-adjustment models developed by the National Association of Insurance Commissioners. States would also be required to regulate and monitor the health insurance industry, again using standards developed by the NAIC. (If the NAIC failed to develop risk-adjustment models and health insurance standards within nine months of the enactment of the legislation, or if those models and standards were not approved by the Secretary of HHS, the Secretary would be responsible for producing them.) Within a year of the issuance of the insurance standards, all states would be required to submit reports to the Secretary of HHS detailing the steps they had taken to implement and enforce the standards.

Although health plans would publish reports on their compliance with national standards of performance promulgated by the Secretary of HHS, states would be required to monitor this process. They would assess the completeness, accuracy, and validity of performance data that health plans submitted to them. (Alternatively, they could contract with private organizations to perform those tasks.) They could also impose penalties on plans that supplied incomplete, inaccurate, or misleading information.

Reallocation of Workers Among Firms

The bipartisan proposal, like many other reform bills, would encourage a reallocation of workers among firms in ways that would increase the proposal's budgetary cost. That process would occur gradually as employment expanded in some firms and contracted in others and as workers sought the jobs that would provide them with the largest combined amount of wages and premium subsidies.

This sorting would occur because the family subsidies would be reduced by up to the amount that employers contributed for insurance; therefore, a worker employed by a firm that did not pay for health insurance would receive a larger subsidy than a worker earning the same wage at a firm that did pay. (In addition to this reallocation, some companies might stop paying for insurance, but the number of firms that would do so would be limited because high-wage workers in those firms would then lose the benefit of excluding health insurance from their taxable income.)

Some workers could gain several thousand dollars in higher wages by moving to a different firm, and over time a significant number of them would probably do so. This reallocation of workers among firms would account for about $11 billion--or 7 percent--of the cost of the subsidies in 2004. In addition to raising the government's costs, the reallocation of workers could reduce the efficiency of the labor market.

The subsidy system would not treat people with similar income and family circumstances alike. Workers who were eligible for subsidies and who were employed at firms that paid for insurance would face larger costs for their insurance when the reduction in their cash wages was taken into account than would similar workers at firms that did not pay.

Disincentives for Work

The bipartisan 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. Such disincentives for work are unavoidable, however, in any proposal that targets subsidies toward the poor and near-poor. Although subsidies for purchasing health insurance would significantly improve the well-being of many low-income people, the subsidies would act to discourage people from trying to raise their income. Some workers would find that, as they earned more, they would have to pay more for health insurance, which would cut into the increase in their take-home wage. In essence, those workers would face an implicit tax on their economic advancement. The magnitude of the implicit tax could be reduced by lowering the subsidies, by phasing out the subsidies over a broader income range, or both. Such changes in the design of the proposal, however, would risk either making insurance unaffordable for some people or significantly increasing the cost of the proposal and extending subsidies to more people who were not poor.

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 extremely high for some families. For workers whose employers did not pay for insurance, the implicit marginal rates from the phaseout of subsidies for low-income families would apply to income between 100 percent and 200 percent of the poverty

level, and the phaseout of subsidies for children and pregnant women would apply to income between 185 percent and 240 percent of poverty.

In 2004, the effective marginal tax on labor compensation (wages and benefits) could increase by between 40 and 65 percentage points for childless workers without employer-paid coverage whose family income lay between 100 percent and 200 percent of poverty. Those levies would be added to the explicit and implicit marginal taxes that such workers would already pay through the income tax and the payroll tax. In the end, workers in those families would keep only 10 to 30 cents of every additional dollar they earned.

For workers in families with children, the increase in marginal tax rates would generally be somewhat smaller--between 25 and 35 percentage points--but that increase would apply to workers with family income in the broader range of 100 percent to 240 percent of poverty. Further, families with income between 185 percent and 200 percent of poverty would face very large increases in their marginal tax rates because both the subsidies for low-income families and the subsidies for children would be reduced for families within that range. Some of those families would find that higher pretax wages or additional hours of work would not increase their take-home earnings at all.

These illustrations apply only to workers whose employers paid none of the costs for insurance: for workers whose employers paid a portion of those costs, the implicit marginal levies would extend over a narrower range of income. Eventually, however, the sorting discussed in the previous section would move some workers eligible for subsidies into firms that did not contribute to insurance, and thus the disincentives for work would apply to those workers as well.

Such high marginal tax rates would be likely to reduce employment, hours of work, and work effort for people affected by the phaseout of the subsidies. For example, a worker with children whose family income amounted to around 185 percent of poverty would be unlikely to seek overtime, because increases in income up to 200 percent of poverty would gain nothing in net income. Similarly, such a worker would see less reason to work hard just to advance to a modestly higher rank, because doing so would yield little if any immediate financial reward; and a secondary worker in the household would be less likely to seek part-time employment. Most workers affected by the phaseout of subsidies would face much less extreme effective marginal tax rates, but these rates would be high enough that some workers would reduce their work effort.

It is important to note that any reduction in employment or hours worked that occurred as a result of this proposal would be voluntary. Unlike proposals that include mandatory payments by employers, the bipartisan proposal would neither raise labor costs nor throw out of work people who wanted to work.

Table 1. Estimated Federal Budgetary Effects of the Bipartisan Proposal
(By fiscal year, in billions of dollars)

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
MANDATORY OUTLAYS										
Medicare										
1 Extension of Bonus Payments in HPSAs	a	a	a	a	a	a	a	a	a	a
2 EACH/REACH	a	a	a	a	a	a	a	a	a	a
3 Reduction in Payments for Hospital Services	0	0	-0.8	-2.3	-4.2	-6.4	-7.1	-8.1	-8.9	-9.8
4 Reduction in Payments for Inpatient Hospital Capital	0	-0.8	-1.0	-1.2	-1.6	-2.1	-2.2	-2.4	-2.7	-2.9
5 Cumulative Expenditure Goals for Physician Services	0	0	0.1	-1.7	-2.3	-1.5	-1.6	-1.9	-2.0	-2.2
6 Real GDP Growth in Volume/Intensity	0	0	-0.3	-0.8	-1.6	-2.5	-3.3	-4.2	-5.3	-6.6
7 Reduce Physician Update	-0.3	-0.4	-0.5	-0.5	-0.5	-0.6	-0.6	-0.7	-0.7	-0.8
8 Coinsurance on Laboratory Services	-0.7	-1.1	-1.3	-1.4	-1.6	-1.8	-2.0	-2.3	-2.6	-2.9
9 Extension of 25% Premium for Part B	0	0.4	0.5	1.2	0.3	-1.8	-3.9	-6.6	-9.9	-12.7
10 Physician Self-Referral	a	a	a	a	a	a	a	a	a	a
11 Prospective Payment for Outpatient Services	0	-0.2	-0.3	-0.4	-0.5	-0.5	-0.6	-0.7	-0.9	-1.0
12 Prospective Payment for Home Health Services	0	-0.5	-0.8	-0.9	-1.0	-1.1	-1.2	-1.3	-1.4	-1.5
13 Medicare Secondary Payer Extensions	0	0	0	0	-1.2	-1.8	-1.9	-2.0	-2.2	-2.3
14 Medicare Secondary Payer - Disabled Threshold	0	0	0	-0.2	-0.2	-0.3	-0.3	-0.4	-0.4	-0.4
Total - Medicare	-0.9	-2.7	-4.3	-6.3	-14.5	-20.3	-24.9	-30.7	-36.9	-43.1
Medicaid										
15 Eliminate Pediatric Immunization Program	-0.3	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2
16 Reduction in DSH Payments	-2.5	-2.7	-3.0	-5.6	-7.4	-7.9	-7.4	-6.9	-6.6	-6.0
17 Acute Payments Cap	-1.0	-1.7	-2.4	-0.8	0	0	0	0	0	0
18 Discontinued Core Benefits	0	0	0	-26.5	-39.5	-44.2	-49.4	-55.0	-61.0	-67.4
19 Cap on Supplemental Benefits Payments	-0.2	-0.3	-0.4	-0.5	-0.6	-0.7	-0.8	-1.0	-1.2	-1.4
20 Increase State Flexibility	a	a	a	a	a	a	a	a	a	a
21 Administrative Savings	0	0	0	-0.4	-0.5	-0.6	-0.7	-0.8	-0.8	-0.9
22 State Maintenance of Effort	0	0	0	-18.4	-27.3	-30.3	-33.5	-36.9	-40.5	-44.4
Total - Medicaid	-4.0	-4.9	-6.0	-52.4	-75.5	-83.9	-92.0	-100.8	-110.3	-120.3
Department of Veterans Affairs										
23 Veterans Affairs, Total Direct Spending	1.2	0.8	0	-1.1	-1.8	-1.9	-2.0	-2.1	-2.1	-2.2
Total - Veterans Affairs	1.2	0.8	0	-1.1	-1.8	-1.9	-2.0	-2.1	-2.1	-2.2
Subsidies										
Premium Subsidies:										
24 For Non-Medicare Poor	0	0	0	54.9	81.9	94.5	108.1	122.5	138.2	154.6
Cost-Sharing Subsidies:										
25 For Non-Medicare Poor	0	0	0	6.8	9.6	10.5	11.4	12.3	13.3	14.3
Total - Subsidies	0	0	0	61.6	91.5	104.9	119.4	134.8	151.5	168.9

Table 1. Estimated Federal Budgetary Effects of the Bipartisan Proposal
(By fiscal year, in billions of dollars)

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Other Federal Programs										
26 Prefund Postal Service Retiree Health Benefits	0	-2.4	-2.5	-2.6	-2.6	-2.8	-2.8	-2.9	-3.0	-3.1
27 Social Security Benefit Effect	0	0	0	0.2	0.5	0.9	0.9	0.9	0.9	0.8
Total - Other Federal Programs	0	-2.4	-2.5	-2.4	-2.1	-1.9	-1.9	-2.0	-2.1	-2.3
Mandatory Administrative Costs										
28 Costs for Administering Subsidy Program	0	0	0	2.3	2.5	2.7	2.9	3.1	3.3	3.6
29 Payments to States for Automobile Coordination Admin.	0	0	0.3	0.1	0.1	0.1	0.1	0.1	0.1	0.1
Total - Administrative and Start-Up Costs	0	0	0.3	2.4	2.6	2.8	3.0	3.2	3.4	3.7
TOTAL MANDATORY OUTLAY CHANGES	-3.7	-9.2	-12.5	-0.2	0.2	-0.3	1.7	2.5	3.5	4.8
DISCRETIONARY OUTLAYS										
Administrative and Start-Up Costs										
30 Administrative and Start-Up Costs	0	0.5	0.5	0.5	0.5	0.5	0.5	0.6	0.6	0.6
Total - Administrative and Start-Up Costs	0	0.5	0.5	0.5	0.5	0.5	0.5	0.6	0.6	0.6
Medicare										
31 Grants	a	a	a	a	a	a	a	a	a	a
Total - Medicare	a	a	a	a	a	a	a	a	a	a
Department of Veterans Affairs										
32 Veterans Affairs - Total Discretionary	a	a	0.1	-3.5	-4.9	-4.9	-5.2	-5.3	-5.5	-5.7
Total - Veterans Affairs	0	0	0.1	-3.5	-4.9	-4.9	-5.2	-5.3	-5.5	-5.7
Public Health Service										
33 Public Health Service - Total Discretionary	a	0.1	0.2	0.5	0.7	0.8	0.8	0.9	0.9	0.9
Total - Public Health Service	0	0.1	0.2	0.5	0.7	0.8	0.8	0.9	0.9	0.9
TOTAL DISCRETIONARY OUTLAY CHANGES	0	0.6	0.8	-2.5	-3.7	-3.6	-3.9	-3.8	-4.0	-4.2
TOTAL OUTLAY CHANGES	-3.7	-8.6	-11.7	-2.7	-3.5	-3.9	-2.2	-1.3	-0.5	0.6

Table 1. Estimated Federal Budgetary Effects of the Bipartisan Proposal
(By fiscal year, in billions of dollars)

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
RECEIPTS										
34 Medical Savings Accounts	a	a	a	a	a	a	a	a	a	a
35 Excise Tax on Insurers for Failure to Comply	a	a	a	a	a	a	a	a	a	a
36 Excise Tax on Employers for Failure to Comply	a	a	a	a	a	a	a	a	a	a
37 Deduction of Health Insurance for Self-Employed	-0.5	-0.4	-0.5	-0.6	-0.9	-2.0	-3.3	-3.5	-3.8	-4.1
38 Deduction of Health Insurance for Certain Individuals	0	-0.2	-0.6	-1.1	-1.9	-1.9	-1.8	-1.9	-1.9	-1.9
39 National Health Service Corps Loan Repayments	a	a	a	a	a	a	a	a	a	a
40 Exemption for High-Risk Health Insurance Pools	a	a	a	a	a	a	a	a	a	a
41 Modify VEBA to Encourage Large Group Purchasing	a	a	a	a	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1
42 Excise Tax on Plan Administrators for Failure to Comply	0	0	0	0	0	0	0	0	0	0
43 Part B High-Income Premium	0	0.6	1.2	1.7	2.2	2.8	3.5	4.5	5.7	7.2
44 Tax Treatment of Long-Term Care Insurance	0	-0.1	-0.4	-0.5	-0.5	-0.6	-0.7	-0.8	-0.9	-1.0
45 Partial Repeal of Cafeteria Plans and FSAs	0	1.5	2.3	2.4	2.7	3.1	3.5	4.0	4.4	4.9
46 Indirect Tax Effects	0	0	-0.1	1.9	2.3	1.8	1.3	0.8	0.3	0.3
TOTAL RECEIPT CHANGES	-0.5	1.4	1.9	3.8	3.8	3.1	2.4	3.0	3.7	5.3
DEFICIT										
MANDATORY CHANGES	-3.2	-10.6	-14.4	-4.0	-3.6	-3.4	-0.7	-0.5	-0.2	-0.5
CUMULATIVE MANDATORY DEFICIT	-3.2	-13.8	-28.3	-32.2	-35.9	-39.3	-40.0	-40.5	-40.7	-41.2
TOTAL CHANGES	-3.2	-10.0	-13.6	-6.5	-7.3	-7.0	-4.6	-4.3	-4.2	-4.7
CUMULATIVE TOTAL DEFICIT	-3.2	-13.2	-26.9	-33.4	-40.7	-47.7	-52.3	-56.6	-60.9	-65.6
Memoranda:										
Subsidies	0	0	0	61.6	91.5	104.9	119.4	134.8	151.5	168.9
Medicaid	-4.0	-4.9	-6.0	-52.4	-75.5	-83.9	-92.0	-100.8	-110.3	-120.3
Administrative and Start-Up Costs	0	0.5	0.8	2.9	3.1	3.3	3.5	3.8	4.0	4.3
Total - New Federal Low-Income Assistance	-4.0	-4.4	-5.2	12.1	19.1	24.3	30.9	37.8	45.2	52.9

SOURCES: Congressional Budget Office; Joint Committee on Taxation.

a. Less than $50 million.

Table 2. Estimated State and Local Budgetary Effects of the Bipartisan Proposal

(By fiscal year, in billions of dollars)

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
STATE & LOCAL OUTLAYS										
Medicaid										
1 Reduction in DSH Payments	0.3	0.3	0.4	0.7	0.9	−0.9	−0.9	−0.9	−0.8	−0.7
2 Acute Payments Cap	0.4	0.7	0.9	0.3	0	0	0	0	0	0
3 Discontinued Core Benefits	0	0	0	−19.9	−29.6	−33.2	−37.1	−41.2	−45.7	−50.5
4 Cap on Supplemental Benefits Payments	0.1	0.1	0.1	0.2	0.2	0.3	0.3	0.4	0.5	0.5
5 Administrative Savings	0	0	−0.2	−0.4	−0.4	−0.5	−0.5	−0.6	−0.6	−0.7
6 State Maintenance of Effort	0	0	0	18.4	27.3	30.3	33.5	36.9	40.5	44.4
7 Other Medicaid	−0.2	−0.1	−0.1	−0.1	−0.1	−0.1	−0.1	−0.1	−0.1	−0.1
Total – Medicaid	0.6	1.0	1.1	−0.8	−1.7	−4.1	−4.8	−5.5	−6.2	−7.1
Administrative Expenses										
8 Expenses Associated with Subsidies	0	0	0	2.3	2.5	2.7	2.9	3.1	3.3	3.6
9 General Administrative and Start–Up Costs	0	0	0.4	0.4	0.5	0.5	0.5	0.6	0.6	0.6
10 Automobile Insurance Coordination	0	0	0.3	0.1	0.1	0.1	0.1	0.1	0.1	0.1
11 Federal Payments for Automobile Insurance Coordination	0	0	−0.3	−0.1	−0.1	−0.1	−0.1	−0.1	−0.1	−0.1
Total – Administrative Expenses	0	0	0.4	2.7	3.0	3.2	3.4	3.7	3.9	4.2
TOTAL STATE & LOCAL OUTLAY CHANGES	0.6	1.0	1.5	1.9	1.3	−0.9	−1.4	−1.8	−2.3	−2.9
Total State & Local Changes	**0.6**	**1.0**	**1.5**	**1.9**	**1.3**	**−0.9**	**−1.4**	**−1.8**	**−2.3**	**−2.9**

SOURCE: Congressional Budget Office.

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

	1998	1999	2000	2001	2002	2003	2004
			Baseline				
Insured	226	228	229	230	232	233	234
Uninsured	40	40	41	42	43	43	44
Total	266	268	270	272	274	276	278
Uninsured as Percentage of Total	15	15	15	15	16	16	16
			Bipartisan Proposal				
Insured	240	243	245	248	250	252	255
Uninsured	26	25	25	24	24	24	23
Total	266	268	270	272	274	276	278
Uninsured as Percentage of Total	10	9	9	9	9	9	8

SOURCE: Congressional Budget Office.

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

	1998	1999	2000	2001	2002	2003	2004
Baseline	1,372	1,488	1,613	1,748	1,894	2,052	2,220
Bipartisan Proposal	1,397	1,498	1,620	1,756	1,901	2,059	2,226
Change from Baseline	25	10	7	7	7	7	6

SOURCE: Congressional Budget Office.