

The Budgetary Treatment of Proposals to Change the Nation's Health Insurance System

The Congress is currently considering various approaches for instituting major changes in the nation's system of health insurance. Some of those proposals would significantly expand the federal government's role in that system, thus raising the question of how such changes might be reflected in the federal budget. This brief describes the approach that the Congressional Budget Office (CBO) will take in judging the appropriate budgetary treatment.¹

In determining the budgetary treatment of a new program, CBO considers how similar existing programs appear in the budget and how the basic principles that underlie federal budgeting may apply. The most straightforward situation is one in which money flows through a federal agency or some entity acting on behalf of a federal agency. In those cases, the cash flows generally appear in the federal budget. But the major changes being contemplated for the nation's health insurance market are quite different from existing federal programs. Many of those changes would involve a mix of governmental activities and private transactions that have some similarities to other programs but are also different in significant ways. In addition, the scope of the changes and the amounts of money involved are substantial; even if there was a clear parallel in an existing but much smaller program, the budgetary treatment of health care legislation would nevertheless merit careful consideration.

In making decisions about budgetary accounting, experts often refer to the 1967 *Report of the President's Commission on Budget Concepts*. That report stated, "To work well, the governmental budget process should encompass the full scope of the programs and transactions that are

within the Federal sector and not subject to the economic disciplines of the marketplace." The commission recommended that "the budget should, as a general rule, be comprehensive of the full range of Federal activities." As the commission noted, however, "the boundaries of the federal establishment are sometimes difficult to draw."

Common Features of Emerging Proposals

Many of the proposals under consideration share some or all of the following features:

- A mandate on all (or most) individuals to have health insurance coverage providing some specified minimum level of benefits.
- A "play-or-pay" requirement, whereby some or all firms would have to either offer health insurance to their employees or make a payment to the federal government.
- New subsidies and expanded eligibility for the existing Medicaid program to make coverage more affordable for some individuals and families.
- New "exchanges" through which individuals and, in some cases, small employers could purchase health insurance. In some proposals, exchanges are envisioned as private online clearinghouses similar to Orbitz or e-health (perhaps authorized or regulated by a federal agency). Under others, they would be much more like governmental entities in that they would be responsible for administering subsidies; for collecting payments for premiums and conveying those funds to insurers; for negotiating with insurers over the benefits offered and the prices charged; and for performing other oversight responsibilities.

1. The Congressional Budget Office will estimate the budgetary impact of legislation as it is being considered by the Congress. If legislation is enacted into law, the Administration's Office of Management and Budget will ultimately determine how its effects will be reflected in the federal budget.

- The establishment of a “public plan” (defined in various ways) to be offered through the exchanges alongside private plans.
- A federal health board with some responsibility for the oversight of—or decisionmaking about—the required level of benefits or coverage or the operations of the exchanges. At this time, the extent of responsibility that such a board might have for the health insurance market is unclear.

The Budgetary Treatment of Various Types of Proposed Cash Transactions of the Government

Some of the budgetary judgments related to current proposals appear to be relatively straightforward in that they clearly involve cash transactions of the federal government or of other entities acting on behalf of the government. Such transactions include the provision of subsidies for some people and businesses; the income and expenditures of a public health insurance plan; the government’s receipts from “play-or-pay” requirements and from penalties imposed on individuals who fail to comply with a health insurance mandate; and “risk adjustment” transactions of the government that shift funds from insurers with lower-risk enrollees to those with higher-risk enrollees.

Subsidies for Some People and Small Firms

Subsidies for the purchase of health insurance would, under some proposals, be delivered to some people and small firms as tax credits; under others, they would be payments made through insurance exchanges or other agencies to insurance carriers. Either way, such subsidies would be direct costs to the federal government and should be reflected in the federal budget—like, for example, outlays for Medicaid and the effects on revenues and outlays from the earned income tax credit.

Expenditures and Income of a Public Plan

Some proposals would require the federal government—or in some cases, the insurance exchanges—to establish a new “public” insurance product to be offered through the exchanges. In many cases, a public plan would compete directly with private plans sold through the exchanges and could be held to similar rules prescribing covered benefits and pricing of those plans. Unlike privately

offered plans, however, the public plan’s initial start-up costs might be covered by the federal government, and in some cases, the rates that it paid providers would be linked to the payment rates of existing public programs. Under some proposals, the public plan would be directly administered by the agency overseeing its establishment, and under others, the overseeing agency would be authorized to use a third-party administrator.

In CBO’s view, the budgetary treatment of a public plan would depend critically on who bore the financial risk. If the federal government stood behind the plan financially, then its expenditures should be considered federal outlays and the payments collected for premiums should be considered as either federal revenues or as offsets to outlays (see the discussion below regarding how that choice would be made). That approach would be consistent with the treatment of expenditures for Medicare, which is one potential model for a public plan. Even if such a plan was administered by a third party, the budgetary treatment of the public plan would be the same as long as the government was backing it financially—because the third party would be acting as an agent of the federal government.

Payments to the Government Under “Play-or-Pay” Requirements or for Noncompliance with the Mandate

Under some proposals, firms would be required to make payments to the federal government if they chose not to offer health insurance to their employees, and individuals who did not comply with the requirement to obtain insurance would have to pay a penalty. Such payments would be equivalent to a tax or a fine, and the government’s receipts should be recorded in the budget as federal revenues.

Risk Adjustment Transactions of the Government

Under some proposals, the government would make additional payments to plans that attracted relatively unhealthy people, drawing those funds from plans with relatively healthy enrollees. Those “risk adjustment” transactions, aimed at improving the functioning of the insurance market and enhancing the availability of private insurance for high-risk individuals, would redistribute funds to the former plans financed by what would essentially be a tax on the latter. Those cash flows should appear in the federal budget.

The Budgetary Treatment of a Federal Mandate

The imposition of a federal mandate requiring individuals to have a certain minimum amount of health insurance coverage raises more complex issues of budgetary treatment. In considering those issues, CBO first addressed two basic questions:

- Can cash transactions between private entities—in which the funds do not pass through the U.S. Treasury—be reflected in the federal budget?
- Does the existence of a federal mandate, by itself, justify inclusion in the budget of the private-sector costs of the mandated activity?

Can Cash Transactions Between Private Entities Be Reflected in the Federal Budget?

The answer is clearly “yes” when a private entity is acting as an agent of the federal government in carrying out a federal program under the government’s direction. For example, the Coal Industry Retiree Health Benefits Program is included in the federal budget, even though its funds do not pass through the Treasury. That program guarantees lifetime health benefits for certain miners and their dependents, and coal companies are required by law to pay health insurance premiums to two privately managed trust funds on behalf of those miners. Even though the benefit plans are nominally private and the federal government plays no role in selecting their trustees, the receipts and spending appear in the federal budget because federal law requires the payment of premiums and determines the use of the money.

Another example is the Universal Service Fund. Federal law requires providers of telecommunications services to make payments to that fund, which is administered by the Universal Service Administrative Company (USAC), a not-for-profit corporation whose board members are nominated by various affected parties and approved by the Chairman of the Federal Communications Commission. Those funds are used to subsidize telecommunications services for high-cost areas, low-income consumers, rural health care providers, schools, and libraries. The payments to the USAC and its disbursements are included in the federal budget because those payments are essentially federal taxes and its disbursements are federal subsidies.

In both cases, a nominally private entity is acting as an agent of the government in carrying out a federal program, and the budget shows the income and expenditures associated with that program.

Does the Existence of a Federal Mandate, by Itself, Justify Inclusion in the Budget of the Private-Sector Costs of the Mandated Activity?

CBO concludes that the answer to that question is “no.” The federal government imposes a variety of mandates on private entities. For example, there are federal requirements regarding minimum wages, occupational safety and health, the treatment of persons with disabilities, food and drug safety, the fuel efficiency of automobiles, and environmental impacts. Many of those laws impose substantial costs on businesses, and some directly affect employees’ compensation, but the budget includes none of their costs. State and local governments impose mandates on businesses and on individuals as well, including requirements related to automobile insurance and auto safety inspections, the installation of smoke detectors, and the use of child car seats and bicycle helmets. The associated costs are not included in government budgets.

Some proposals under consideration would require all U.S. citizens or legal residents to have a certain minimum amount of health insurance. Existing mandates, like those cited above, are not so broad and do not affect as many people as would a mandate to buy health insurance, which might be legally avoided only by leaving the country. But the fact that one can avoid a mandate imposed on businesses by closing down a business, or a mandate to buy auto insurance by not owning a car, does not distinguish those mandates—as a matter of budgetary principle—from a broader mandate imposed on all citizens. CBO therefore concludes that a national requirement for individuals to buy health insurance would not, by itself, justify including the costs of that insurance in the federal budget and that other factors, in addition to the existence of a mandate, should be considered in making that determination.²

What are those factors? To the extent that firms or individuals would be purchasing insurance from the govern-

2. Regardless of whether CBO concluded that the private costs of purchasing insurance should be included in the federal budget, CBO’s cost estimates for legislation would include an analysis of the costs of carrying out a mandate, as required under the Unfunded Mandates Reform Act.

ment or via some entities acting on behalf of the government, the cash flows to and from the government (or such entities) should appear in the budget. But the budgetary treatment of purchases of insurance from private companies is more complicated. At its root, the key consideration is whether the proposal would be making health insurance an essentially governmental program, tightly controlled by the federal government with little choice available to those who offer and buy health insurance—or whether the system would provide significant flexibility in terms of the types, prices, and number of private-sector sellers of insurance available to people.

In CBO's view, the former—a governmental program—belongs in the federal budget (including all premiums paid by individuals and firms to private insurers), but the latter—a largely private-sector system—does not. An example of the latter is the automobile insurance market. There is an active private market for automobile insurance; even though states require the purchase of specified minimum amounts of some types of coverage, automobile owners generally have many choices of how much coverage to acquire, which insurer to use, and what price to pay.

Although the appropriate budgetary treatment for the two approaches differs starkly, there is no well-defined dividing line between the two concepts. Rather, proposals may fall at various points along the broad spectrum between the two extremes, and characterizing a proposal as being in one category or the other can be challenging. In assessing where, along the spectrum, a particular proposal falls, CBO will consider a number of criteria, including these:

- Is the consumer likely to be able to choose among *a number of insurance plans* with differing degrees of comprehensiveness?
- If there are plans with different levels of coverage, will they cover a *broad enough range* to offer consumers a meaningful choice?
- Is the consumer likely to be able to choose among *several different insurance companies* competing on price? (The particular role of a public plan in that determination is discussed below.)

The extent to which a proposal would constrain individuals' choices regarding coverage levels can itself be difficult

to measure, but the actuarial values from which individuals would be allowed to select provide a useful metric. (An insurance policy's actuarial value is the percentage of expected health claims for covered services that an insurance plan will pay.)³ Estimates of the actuarial value of employment-based health plans vary, but typical plans appear to have an actuarial value that is between 80 percent and 95 percent, reflecting in part the favorable tax treatment afforded to such plans. Policies purchased in the individual insurance market generally have a lower actuarial value. The actuarial value of Medicare's benefits, if offered to a nonelderly population, has been estimated at roughly 75 percent.⁴

CBO will assess whether a proposal would tightly control the private insurance market by examining, among other characteristics, the number and range of allowed benefit levels in terms of their actuarial values. A proposal that would limit insurance plans to one or two specific levels of benefits, for example, would be offering consumers little choice. Setting a very high minimum actuarial value (termed the "minimum creditable coverage") would limit the range of consumers' choices, as would setting a narrow range for actuarial values—if, for example, plans had to have an actuarial value of at least 85 percent but not more than 90 percent. CBO will deem proposals that set minimum creditable coverage at more than 80 percent to be too constraining to offer consumers substantial choice.

In sum, the existence of a mandate, by itself, is not sufficient cause to bring transactions between private-sector entities into the federal budget. Similarly, the existence of a tightly regulated but still voluntary activity is also insufficient to bring such transactions into the budget. (Medigap policies, which are supplemental private health insurance policies to fill the gaps in Medicare coverage, are an example of the latter.) In CBO's view, a combination of the two—a mandate and tight federal control over how that mandate can be met—is necessary and sufficient to

3. For a more detailed explanation of actuarial values and how they are calculated, see Congressional Budget Office, *Key Issues In Analyzing Major Health Insurance Proposals* (December 2008), pp. 64–65.

4. Chris L. Peterson, *Setting and Valuing Health Insurance Benefits*, R40491 (Congressional Research Service, April 6, 2009). For additional discussion of the actuarial value of Medicare's benefits, see Congressional Budget Office, *Key Issues In Analyzing Major Health Insurance Proposals* (December 2008), p. 92.

justify recording the affected private-sector transactions in the federal budget.

Under that criterion, different segments of the health insurance market could be treated differently in the budget if they were regulated differently. For example, in conjunction with a mandate to purchase insurance, a tightly regulated market for individual or small-group coverage could be accompanied by a much less constrained market for other forms of employer-sponsored insurance; if so, purchases of individual or small-group policies might be included in the budget, whereas other employers' purchases of insurance might not be.

The Budgetary Treatment of Insurance Exchanges

Many of the proposals under consideration would establish some sort of insurance "exchanges." Under some proposals, those exchanges would essentially be private clearinghouses. Under others, exchanges would collect payments from individuals and perhaps from employers, and would then pay premiums to participating plans. Exchanges might be operated by or under the aegis of the federal government, or they might be operated by states or groups of states.

The question arises as to whether payments by individuals and employers that pass through exchanges should be considered receipts of the federal government and premiums paid through exchanges to insurance companies as outlays of the government. (Alternatively, those transactions could be considered private transactions that should not be reflected in the federal budget.) In CBO's view, the answer partly depends on whether individuals and firms would direct their payments *to exchanges* that in turn would pay insurers, or whether individuals and firms would make their payments via the exchanges *to the insurers themselves*. In the former case, the answer would also depend on whether the exchanges were considered to be federal entities (either federal agencies or nonfederal parties acting as agents of the federal government) or not.

If payments were made to and by exchanges, and if the exchanges were effectively federal entities, then the payments should be included in the federal budget. However, if the payments were made directly from individuals and firms to insurance companies via exchanges, or if the payments were made to and by the exchanges but the

exchanges were not federal entities, then the payments should not be included in the budget (unless other criteria would justify their inclusion in the budget).

Exchanges that would be federally operated or administered by third parties acting as agents of the federal government would be deemed federal. For example, if proposals specified in detail the duties of exchanges, the kinds of products that could be offered through them, and their oversight responsibilities, then CBO would conclude that the exchanges should be treated as federal even when operated by other parties. If, instead, proposals delegated the determination of such specifications to a federally established board, the exchanges would still be operating as arms of the federal government. Although state agencies cannot be required to serve as agents of the federal government, under some plans states could choose to assume those responsibilities, and CBO would treat them according to these same criteria.

In contrast, if proposals call for exchanges that would simply be clearinghouses to facilitate the purchase of insurance from a variety of private insurers—serving as a marketplace for health insurance plans but not regulating that market themselves—then CBO would not view the exchanges as federal agencies. In such cases, the treatment of the cash flows would depend on whether that portion of the system was inherently governmental—that is, whether there was a mandate on individuals to purchase insurance and how tightly constraining that mandate was, as discussed earlier.⁵

The availability of a public plan through an exchange raises an additional set of issues about whether consumers who purchase coverage through that mechanism would have a meaningful set of choices available to them. Specifically, if a public plan dominated an exchange-based market, then that component of the health insurance system would, in practice, be largely governmental. In that case, all of the transactions of the exchange should properly be considered part of the budget—and premium collections should be recorded as revenues, for reasons discussed below—even if the number and range of benefit levels available through the exchange remained broad. The nature of the competition between a public plan and

5. In general, if exchanges are deemed to be federal, their operating costs should be included in the federal budget.

Table 1.

The Budgetary Treatment of Various Aspects of Health Insurance Proposals

	Individual Mandate; Health Insurance Is Largely Governmental (Tightly Constrained)	Health Insurance Is Largely Private (Loosely Constrained)
Subsidies	In budget (Outlays or revenue losses)	In budget (Outlays or revenue losses)
Play-or-Pay Payments	In budget (Revenues)	In budget (Revenues)
Individual Mandate Penalties	In budget (Revenues)	In budget (Revenues)
Risk Adjustment Transactions	In budget (Revenues and outlays)	In budget (Revenues and outlays)
Transactions of Public Plans	In budget (Revenues and outlays)	In budget (Net outlays)
Premiums Paid Directly to Insurers	In budget (Revenues and outlays)	Not in budget
Premiums Paid for Employer-Sponsored Insurance	In budget (Revenues and outlays)	Not in budget
Premiums Paid to Exchanges		
Exchanges are governmental	In budget (Revenues and outlays)	In budget (Net outlays)
Exchanges are not governmental	In budget (Revenues and outlays)	Not in budget

Source: Congressional Budget Office.

Note: Different segments of the health insurance market could be treated differently in the budget if they are regulated differently.

private plans would probably vary geographically, but if the share of individuals purchasing coverage through exchanges who were projected to enroll in a public plan approached or exceeded two-thirds nationwide, CBO would consider the exchange system to be essentially governmental.

Should Income from Premiums Be Considered Federal Revenues or Offsets to Federal Spending?

If payments of health insurance premiums should be recorded in the federal budget, then another question arises: How should such collections be classified in the budget? Money collected by the federal government and recorded in the budget can be classified as either governmental receipts (typically called revenues or receipts) or as offsets to spending (that is, amounts deducted from outlays to yield net outlays). For the most part, revenues are collections from the public that result from the exercise of the government’s sovereign power to tax or otherwise compel payment. Offsets to outlays, by contrast, are typically businesslike transactions with the public (that is, payments from the public in exchange for goods or ser-

vices); depending on whether the collections are credited to specific spending accounts, they may be labeled either “offsetting receipts” or “offsetting collections.” For example, premiums for Parts B and D of Medicare that are paid through withholding from Social Security benefits; income from the sale of timber, minerals, power, and postage stamps; and customs and passport fees are all currently classified as offsetting receipts or collections.

If income from premiums was counted as federal revenues and an equal amount of expenditures was counted as outlays, there would be no effect on the federal deficit—but the total size of the budget would be greater, indicating a greater scope of sovereign governmental activity. In contrast, if income from premiums was counted as an offset to outlays and was matched by an equal amount of outlays, federal revenues would not be affected and net outlays would not change, indicating that the new activity was primarily businesslike or market-oriented.

In CBO’s view, a requirement that individuals purchase health insurance combined with tight federal constraints on the market for such insurance or a dominant role for a public plan would constitute a fundamentally govern-

mental system, reflecting the exercise of the government's sovereign power. In those situations, premiums appearing in the budget—for a public plan or for insurance purchased through exchanges or in the private market—should be recorded as federal revenues. That determination could apply either to the health insurance market as a whole or to just a portion of it (for example, the market for individual or small-group insurance).

In contrast, if there was no mandate or if a mandate was imposed in conjunction with an active, loosely restricted private market for health insurance, premiums appearing in the budget—for a public plan or for insurance purchased through exchanges operated by the government—would be associated with businesslike transactions and should be recorded as offsets to outlays.

Conclusion

The bullets below and the table on the facing page summarize CBO's judgments about the appropriate budgetary treatment of various aspects of current proposals to change the U.S. health insurance system:

- Premium income—for a public plan (or plans) and for insurance purchased through exchanges or in the private market—should be classified as federal *revenues* if there is an individual mandate and tight government control of the insurance market. The corresponding expenditures should also be recorded as outlays in the budget. Similarly, if there is an individual mandate and a dominant public plan available to some segments of the insurance market, premiums and outlays for those segments of the market should appear in the budget, and the premium income should be classified as revenues.
- Premium income should be classified as an offset on the *outlay* side of the budget—and the corresponding spending counted as outlays—if:
 - Premiums are collected for a public plan but there is no mandate, or
 - There is an individual mandate in conjunction with an active, loosely restricted private market, and premiums are collected for a public plan or by governmental exchanges.
- Outlays for premiums and income from the receipt of those premiums should not appear in the federal budget if:
 - There is no mandate and no public plan, or
 - There is an individual mandate and an active, loosely restricted private market, and if premiums are paid through nongovernmental exchanges or directly to insurers.