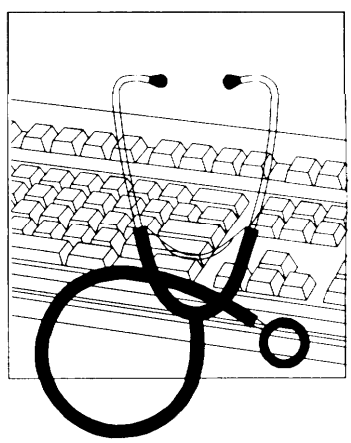
Overview of Selected Issues 3

Provisions in the reform proposals that affect the federal budget fall into two general categories:

- those that affect federal outlays, such as provisions that provide insurance premium subsidies or establish new benefits; and
- those that affect federal revenues, such as provisions that impose new taxes on individuals and/or businesses.

The following discussion examines these two general budget categories as contained in the major pieces of health reform legislation introduced in the 103d Congress. The chapter highlights key determinants necessary to estimate budget items falling under these two categories. The discussion is not formulated around any specific proposal. Rather, it focuses on general types of reform provisions and their implications for the federal budget.

Table 3-1 summarizes provisions in the major health reform legislation introduced in the 103d Congress at the time of writing, the direction of effect of these provisions on the federal budget; and the major factors necessary to estimate the magnitude of their effect. [1]



PROVISIONS THAT AFFECT FEDERAL OUTLAYS

Federal outlays for health care under reform can change either as a result of savings from existing public programs or increases in spending for new benefits, new programs, or subsidies for the purchase of private health insurance. To reduce federal spending, nearly all major health reform legislation introduced in the 103d

[1] Only bills introduced before February 1, 1994 were considered. However. the issues raised in the chapter are relevant to many approaches to rcform and to bills Introducd after February 1, 1994.

TABLE 3-1: Overview of Federal Budget Effects of Health Care Reform

Federal budget-related provisions	Potential budgetary effects	Major determinants of estimates	Reform proposals
Federal outlays			
Expenditures for subsidies or vouchers	Increase in federal spending	Baseline estimates of income distribution by family size	Affordable Health Care Now Act of 1993 (H R 3080/S 1533)
		Baseline estimates of wage distribution by firm size	Consumer Choice Health Security Act of 1993 (H R 3698/S 1743)
		Baseline expenditures for standard benefit package	Health Equity and Access Reform Today Act of 1993 (H R 3704/S 1770)
		Estimated premium level and growth under reform	Health Security Act (H R 3600/S 1757)
		Assumption about employers' and employees' behavioral responses	Managed Competition Act of 1993 (H R 3222/S 1579)
		Assumption about individuals' demand elasticity for Insurance and medical care	
Expenditures for new benefits	Increase in federal spending	Baseline estimates of the size of eligible population and partcipation rates	American Health Security Act of 1993 (H R 1200/S 491)
		Current expenditures for covered services	Health Equity and Access Reform Today Act of 1993 (H R 3704/S 1770)
		Assumption about inducement effects	Health Security Act (H R 3600/S 1757)
		Assumption about future growth rates of expenditures	
Savings from Medicare and Medicaid, and other public health Insurance programs	Decrease in federal spending	Baseline estimates of program expenditures and growth	Affordable Health Care Now Act of 1993 (H R 3080/S 1533)
		Assumption about providers behavioral responses	Consumer Choice Health Security Act of 1993 (H R 3698/S 1743)
		Assumption about Individuals' demand elasticity for Insurance and medical care	Health Equity and Access Reform Today Act of 1993 (H R 3704/S 1770)
			Health Security Act (H R 3600/S 1757)
			Managed Competition Act of 1993 (H R 3222/S 1579)

(continued)

TABLE 3-1: Overview of Federal Budget Effects of Health Care Reform (Cont'd.)

Federal budget-related provisions	Potential budgetary effects	Major determinants for estimates	Reform proposals
Federal revenues			
Taxes on income and payroll[c]	Increase or no change in federal revenue	Baseline taxable income and wage distribution by tax brackets	American Health Security Act of 1993 (H R 1200/'S 491)
		Baseline Insurance expenditures under current regime	Health Security Act (H R 3600/S 1757)
		Estimated premium levels (or Insurance expenditures) and growth under reform	
		Assumption about behavioral responses to higher income (e g use of other nontaxable compensation elasticity of labor supply)	
Taxes on tobacco products	Increase in federal revenue	Baseline expenditures (and consumption) of tobacco products	American Health Security Act of 1993 (H R 1200/S 491)
		Assumption about elasticity of demand	Health Security Act (H R 3600/S 1757)
Recovered tax expenditures[d]	Increase or no change in federal revenue	Baseline distribution of tax expenditures by tax brackets	Health Security Act (H R 3600/S 1757)a
		Baseline distribution of health benefits by tax brackets	Managed Competition Act of 1993 (H R 3222/S 1579)
		Assumption about behavioral responses to higher taxes (e g use of other nontaxable compensation elasticity of labor supply)	
New tax expendltures[d]	Decrease in federal revenue	Baseline distribution of tax expenditures by tax brackets and self-employment	Affordable Health Care Now Act of 1993 (H R 3080/S 1533)
		Assumption about estimated premiums under reform	Health Equity and Access Reform Today Act of 1993 (H R 3704/S 1770)
		Assumption about costs and particlpation rates for tax-exempt insurance	Health Security Act (H R 3600/S 1757)a
			Managed Competition Act of 1993 (H R 3222/S 1579)

[3] Not al I factors I listed here are necessary for the esimation of each provision For example the baseline estimates of wage distribution by firm IS only needed for the estimates mates of a firm subsidy, not an individual subsidy

b proposals are from the 103d Congress

[c] New tax revenues could be generated either with an Increase of tax rates or as result of higher income and wage Some reform proposals would also impose a higher tax rate on payroll or impose a new assessment on the payroll of certain employers

d some reform proposals Would eliminate or restrict the tax exclusion of certain health care related expenses that are tax-exempt under current law Some proposals would Introduce new tax expenditures either with a tax credit system for health care expenses or by excluding certain health care related expenses from taxable income

SOURCE Off Ice of Technology Assessment , 1994

Congress propose cost-saving strategies for existing public insurance programs, especially Medicare and Medicaid.

Many proposals also call for additional federal spending to subsidize the purchase of health insurance. In addition, some proposals would create new benefits, such as prescription drug coverage and long-term care, to address health care needs of certain population groups. At the most comprehensive level, some proposals would create a national health insurance program. These provisions would inevitably increase federal spending on health care.

This section will focus on three general budget items common to most of the reform proposals:

- expenditures for insurance premium subsidies or vouchers,
- expenditures for new benefits and programs, and
- savings from existing public insurance programs.

For each item, factors that might affect analysts' estimates or contribute to the variations in those estimates will be identified and described.

Subsidies or Vouchers for Health Insurance and/or Health Care

Various reform proposals have adopted markedly different approaches to extending insurance coverage to all or part of the uninsured population. The American Health Security Act (H. R.1200/S.491) would establish a national health insurance program and directly involve the federal and state governments in providing health insurance to all legal residents. The other major reform proposals would maintain a system largely based on private health insurance. Some of these private insurance-based proposals have no requirements regarding the purchase or provision of insurance, and would rely exclusive y on various regulatory and/or market mechanisms to increase the availability and purchase of health insurance. Others would require individuals to buy insurance and/or employers to provide insurance (individual and/or employer mandates). All the major reform proposals, that retain the private insurance market, would provide some level of government assistance in the form of subsidies, vouchers, or tax credits for those with incomes or wages below a given level. [1] Table 3-2 provides an overview of the provisions in various reform proposals aimed at improving access to insurance and/or health care services.

In general, additional federal expenditures that result from helping individuals to buy insurance are a function of the number of individuals and/or employers who would receive the assistance (e.g., subsidies and vouchers) and the amount of assistance across individuals and/or firms.[2] Determinants of these estimates include: eligibility for subsidies or vouchers, behavioral responses to subsidies or vouchers, and the premiums under reform.

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[1] For example, both the Health Security Act and the Managed Competition Act (H. R. 3222/S. 1579) have prescribed premium subsidies for the purchase of private health insurance. The Health Equity and Access Reform Today Act (H. R.3704/S. 1770) would use federal vouchers to subsidize the cost of qualified health plan premiums for h)w-income individuals. The Consumer Choice Health Security Act (H. R.3698/S. 1743) would provide no direct incentive or assistance in the purchase of health insurance, but instead would rely on income tax credits to offset indi-v iduals' health care spending (discussed in the new tax expenditures section below).

[2] In addition, certain administrative costs will be incurred in administering the premium subsidies. The magnitude of administrative costs related to premium subsidy program will depend on the mechanisms of payments for the premium subsidies used by different reform proposals. Under the Health Security Act, for example, the disbursement of premium subsidies is made through a single lump-sum payment to the regional alliances for the difference between alliance payments (premiums and administrative costs) and alliance receivables (employer and individual contributions, federal and state payments for Medicare and Medicaid beneficiaries enrolled in the alliance). Under the Health Equity and Access Reform Today Act (H. R.3704/S. 1770), the premium subsidy is administered through a voucher system distributed to individuals, which presumably would incur much higher administrative costs.

TABLE 3-2: Provisions in Selected Reform Proposals for Federal Assistance for Insurance and/or Health Care[a]

Reform proposals	Federal policies to subsidize the purchase of insurance and/or health care
Affordable Health Care Now Act of 1993 (H R 3080/S 1533)	Subsidy for premium costs above 150 percent of the average premium for individuals with pre-existing conditions.
Consumer Choice Health Security Act of 1993 (H R 3698/S 1743)	Federal grant to the states for health care expenditures for famlies with Incomes below 150 percent of poverty level,
Health Equity and Access Reform Today Act of 1993 (H R 3704/S 1770)	Federal vouchers for Insurance premiums with a phase-in schedule from 1997 to 2004 for families with Incomes between 90 to 240 percent of the poverty level.
Health Security Act (H R 3600/S 1757)	Subsidy for the "family share" of the premium for working famlies with Incomes below 150 percent of the poverty level
	Subsidy for the 80 percent share of premium for non-working families with Incomes below 250 percent of the poverty level
	Subsidy for employer premium spending 1) employers' premium spending capped at 79 percent of total payroll, 2) additional subsidies for smaller employers with 75 or fewer workers and average annual wage under $24,000
	Subsidy for "employer share" of premium for retired workers aged 55 to 65 not covered by Medicare
Managed Competition Act of 1993 (H R 3222/S 1579)	Subsidy for full premium costs for families with incomes below 100 percent of the poverty level
	Subsidy for part of the premium costs on a sliding scale for families with Incomes between 100 and 200 percent of the poverty level

[a] This table includes only reform proposals with specific provisions for assistance or federal subsidies for health care spending Proposals such as the [a]Amercan Health Security Act (H R 1200 S 491), which provides health coverage to all legal residents regardless of economic status, are not discussed here Additionally the tax credit provisions prescribed **in** the Affordable Health Care Now Act and the Consumer Choice Health Security Act are discussed in the new tax expenditures section below
[b] proposals are from 103d Congress

SOURCE Off Ice of Technology Assessment 1994

Eligibility

The information needed to calculate the number of individuals or organizations e] eligible to receive subsidies will naturally depend on how eligibility is determined. In general, the more complex the eligibility criteria, the greater the informational requirements. In the health reform proposals currently before the 103d Congress, eligibility criteria include: income; income and employment; and employer size, payroll, and health spending.

In some cases information needed to determine the size of the eligible population may not be readily available, or analysts may disagree on the appropriateness of certain data sources. For example, information on the distribution of employers by firm size and average payroll is one area where analysts use different data sources and methods and arrive at different estimates for the number of workers in subsidy-eligible firms (5).

Behavioral Responses to Subsidies or Vouchers

In some instances, the eligibility criteria for premium subsidies or vouchers may encourage changes in employment patterns or firm organization. For example, if smaller firms with lower average payrolls receive higher premium subsidies, employers might attempt to create small subsidiary firms with lower average wages to qualify for the higher subsidy. In this case, assumptions about individual and/or employer responses are needed to estimate federal spending on premium subsi-

dies. Analysts may differ in how they incorporate these behavioral responses in their estimates of the costs to the federal government.

Health Insurance Premiums Under Reform

The estimates of baseline expenditures for the services covered by insurance provide the basis for premium estimates under reform. The higher the estimated baseline expenditures, the higher the projected premium levels. When universal coverage (or expanded coverage) is provided, premium estimates also have to reflect expenditures associated with additional demand for health services among the previously uninsured population and individuals with less coverage than provided under the "standard benefit package."[3] In addition, the premium estimates under universal coverage or expanded coverage would have to account for changes in the amount of cost-shifting. If analysts differ in their estimates of the baseline expenditures for covered services, or make different assumptions about the magnitude of inducement effects and cost-shifting, their premium estimates and, accordingly, their subsidy estimates, will differ.

Additionally, analysts might also differ in their assumptions regarding the growth rate of premiums under health reform. Analysts who assumed a higher premium growth rate than that of others would arrive at a higher estimates for premium subsidies or vouchers, all other things being equal.

Expenditures Associated with New Public Programs and Benefits

Table 3-3 provides an overview of the provisions in various health care reform proposals that prescribe new benefits or services (e.g., preventive care, prescription drug coverage) for existing public programs or create new "entitlement-like" programs (e.g., long-term care) for certain populations with special health care needs.

How federal expenditures would be affected by certain new benefits depends on the characteristics of the benefits, as well as the federal government's involvement in providing those benefits.[4] In general, estimates of additional federal outlays attributable to new benefit provisions are affected by how analysts estimate and incorporate four parameters: 1) the number of beneficiaries, 2) baseline utilization and expenditures for the new services or benefits, 3) the inducement effects on the additional demand for the new services or benefits, and 4) the growth rate of expenditures for the new services or benefits in future years. [5]

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[3] The provision of universal health insurance coverage would essentially lower the costs of health care faced by individual consumers who are uninsured or underinsured (i.e., have coverage less than the "standard benefit package") under the current system. Ev idence from the Rand Health Insurance Experiment suggests that the demand for services, and accordingly the associated expenditures, increases as the costs of services borne by individual consumers fall (17).

[4] In cases where federal payments for the new benefits are capped by a designated amount in the legislation, the issue for analysts and Policy - makers becomes less about expenditure estimates and more about whether the policy objectives can actually be achieved as originally intended in the reform proposal.

[5] [n cases where new agencies are needed, or new responsibilities and functions have to be added to the existing agencies to administer the new benefit programs, additional federal outlays would also be accrued for administrative functions. Experience from existing public insurance programs such as Medicare suggest, however, that additional federal spending for administration under reform would be relatively insignificant. HCFA estimated that Medicare overhead for administrative functions as a percentage of Medicare expenditures was only 2.1 percent in 1991 (1,2). However. not all administrative costs are borne by the federal government. Depending on the specific reform provisions, certain administrative requirements may also be imposed on state governments and numerous parties in the private sector (e.g., insurers, providers, and individuals). This report focuses only on the federal budget effects of health reform. For a detailed discussion of the administrative costs issues related to the projections of health care reform, see the OTA assessment *Under.\ tanding Estimates of National health Expenditures Under Health Reform (45).*

TABLE 3-3: Provisions in Selected Reform Proposals That Establish New Public Programs or Benefits

Reform proposals	New benefits in existing public programs or new benefit programs
Affordable Health Care Now Act of 1993 (H R 3080/S, 1533)	No new benefits in existing public programs or new benefit programs
American Health Security Act of 1993 (H R 1200/S. 491)	All public health Insurance programs (except the Indian Health Service and VA) are repealed and replaced with a national health Insurance program
Consumer Choice Health Security Act of 1993 (H R 3698/S 1743)	No new benefits in existing public programs or new benefit programs
Health Equity and Access Reform Today Act of 1993 (H R 3704/S 1770)	No new benefits in existing public programs or new benefit programs
Health Security Act (H R 3600/S 1757)	Medicare Part-B prescription drug benefits Community-based long-term care program for the severely disabled
Managed Competitopm Act of 1993 (H R 3222/S 1579)	No new benefits in existing public programs or new benefit programs

[a] Proposals are from 103d Congress

NOTE Changes in eligibility criteria for public programs are not discussed here

SOURCE Off Ice of Technology Assessment, 1994

Eligibility and Participation Rate

In some cases, the baseline estimate of the eligible population is readily available because the population is relatively well defined. Analysts need only make an assumption as to whether all of the eligible individuals would participate in the benefit program. This assumption may either be based on experiences from similar programs, or when no similar program exists, on analysts' judgments.

In some other cases, however, estimates of the eligible population are more uncertain. For example, estimates of the number of severely disabled persons who meet certain eligibility criteria depend not only on the qualityty of the survey data but also on whether the eligibility criteria themselves can be clearly defined.[6] Self-reported survey data on the health of individuals may be subject to reporting bias and misrepresent the size of population with certain health conditions. Whether the eligibility criteria are clearly defined in the legislation or the extent to which there is discretion (by the examining physicians or other individuals) to determine eligibility are also important factors that can lead to an unexpected increase in the size of the population eligible for new benefits.

Current Expenditures, Inducement Effects, and Growth Rate

In addition to the number of participating beneficiaries, analysts' estimates of the initial expenditures for new benefits are based on the current use and expenditures of the services, and assumptions about the additional demand due to lower effective prices for the services. The estimated base-year expenditures are extrapolated to future expenditures based on analysts' assumptions about the growth rates of expenditures for the public programs involved. If analysts differ in their estimates or assumptions of any of the three parameters (i.e., current expenditures, inducement effects, and future growth rates), their estimates of expenditures for the new benefits would differ as well.

[6] OTA is currently conducting a separate study assessing issues related to the eligibility criteria for federally mandated long-term care programs. The study, *Eligibility Criteria for A Federally-Mandated Long-Term Care Program*, is expected to be completed in summer 1995.

Savings from Existing Public Programs

Many reform plans have proposed ways to achieve savings from existing public programs, especially from Medicare and Medicaid. In some cases these savings are intended to help pay for new benefits. Savings could result from reducing payments to health care providers, increasing beneficiaries' premiums, increasing patient cost-sharing, or eliminating programs altogether.[7]

Analysts' estimates of savings from existing programs are determined by baseline expenditures, the magnitude of changes in provider payments and patient cost-sharing, and behavioral responses to the proposed changes in provider payments or patient cost-sharing.

Growth Rates of Public Programs Expenditures

Information on current federal expenditures for public programs is readily available. In contrast, analysts must estimate program expenditures in future years based on assumptions about public program growth rates under current law. If growth rates are overstated, the projected savings also will be overstated. For example, reform proposals that tie the expenditure growth rates of public programs to general inflation will not yield savings if spending on public programs grows at the rate of inflation without reform. In the past, analysts have tended to underestimate the growth rate of Medicare and Medicaid spending (30).

Behavioral Responses

Estimates of potential savings from public programs are also affected by assumptions about how patients respond to higher copayments and how providers respond to lower payments for particular services. Patients are likely to reduce their use of health services when a higher copayment is required (44). Providers who face lower payments for particular services may try to substitute nonregulated services, substitute higher-payment services, or increase the overall volume of services they provide (20). Providers may also adjust the coding of services. In general, analysts would have to make assumptions about both the likelihood and the magnitude of such behavioral responses.

PROVISIONS THAT AFFECT FEDERAL REVENUES

To help finance new benefit programs or expanded coverage, many reform proposals would seek additional sources of revenue in addition to the various cost-saving efforts. In most cases, the revenue would come from new taxes or restrictions on health-related tax expenditures. Examples of the latter include disallowing the use of cafeteria plans and flexible spending accounts for health benefits,[8] setting a cap on the tax exclusion of health insurance premiums, and repealing the tax exclusion of employer-paid health premiums.

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[7] Both the Health Security Act and the Health Equity and Access Reform Today Act (H. R.3704/S. 1770), for example, would rely on both mechanisms to reduce federal spending in the Medicare and Medicaid programs. The Managed Competition Act of 1993 (H. R.3222/S. 1579) also proposes to increase Medicare Part-B premiums, while at the same time repealing the Medicaid program. Both the Affordable Health Care Now Act (H. R.3080/S. 1533) and the Consumer Choice Health Security Act (H. R.3698/S.1743) propose to restructure and cap the growth of the Medicaid program and either increase the Medicare Part-B premium or establish copayments for home health care, skilled nursing facilities, and laboratory services.

[8] A Cafeteria plan, as prescribed in the Internal Revenue Code (section 125), is a benefit plan sponsored by employers where all participating employees can choose among two or more benefits consisting of cash and qualified benefits (e.g., health insurance, life insurance). Under the provisions of section 125, employers may contribute flexible benefit credits that employees can allocate toward the purchase of health benefits. Employers may also setup salary conversion mechanisms that allow employees to pay for health insurance premiums with pretax income. In addition, employers may also provide flexible spending accounts allowing employees to contribute pretax funds for health care expenditures.

In contrast to provisions that would raise new tax revenues or recover a portion of the existing tax expenditures, some reform proposals would reduce tax revenues from certain sources to provide incentives or assistance for purchasing health insurance. Examples include a higher tax deductibility of health insurance premiums for the self-employed, tax-exempt individual medical savings accounts, and income tax credits for health care spending.

The focus of this section is on three general revenue sources common to most of the reform proposals:

- revenues from individual and corporate income taxes, payroll taxes, and excise taxes on certain commodities;
- revenues from recovered tax expenditures;
- revenue loss resulting from new tax expenditures.

The section will discuss issues that might affect analysts' estimates or contribute to the variations in those estimates for each budget item. Table 3-1 identifies the relevant reform proposals and the major determinants of the estimates under each budget item.

New Taxes on Income, Payroll, and Certain Commodities[9]

Additional tax revenues from income and payroll can result from either a higher tax rate or a larger tax base as income and payrolls increase. Excise taxes on certain commodities (e.g., cigarettes) would also bring in additional revenues. Table 3-4 provides an overview of the provisions in various reform proposals that directly increase tax liability.

The information required for analysts' estimates depends on the types of tax revenues involved. For example, estimates of the potential revenues from a "sin tax" on tobacco products hinge mostly on data about current tobacco consumption and consumers' responses to higher prices (i.e., the price elasticity of demand for tobacco products). If information about the demand elasticity for tobacco products is readily available, the revenue estimation is relatively straightforward.

If health reform lowers health expenditures, wages and corporate profits may increase and lead to higher tax revenues. Estimates of this type of income-based tax revenue will mostly depend on analysts estimates of health benefits spending before and after the health reform as well as how much of the potential savings are passed through in the form of corporate profits or employee wages. Other things being equal, analysts who base their estimates on a relatively lower baseline spending would arrive at a lower level of tax revenues. Analysts who based their estimates on a relatively lower health spending under reform would arrive at a higher level of tax revenues.

Recovered Tax Expenditures

Under the current system, the federal government subsidizes spending on health care and health insurance through various tax expenditures. Examples of general categories of health-related tax expenditures under the Internal Revenue Code include: the exclusion from employee taxable income of employer contributions to workers' health care benefits (sections 105 and 106), and the personal deduction for a specified portion of the health insurance premium paid by self-employed individuals (section 162).

Many reform proposals before the 103d Congress rely on recoverable tax expenditures as a potential source of revenue. Table 3-5 provides an overview of the provisions in various reform proposals that would recover a portion of the tax expenditures.

[9] The discussion here focuses only on tax liabilities directly imposed on individuals and employers. The 1 percent assessment of gross Premium receipts imposed on the accountable health plans, as prescribed in the Managed Competition Act (H. R.3222, S. 1579) is not discussed here. In general, the estimate of potential revenues from this particular assessment is a function of premium levels, premium growth rates, and enrollment.

TABLE 3-4: Provisions in Selected Reform Proposals That Increase Tax Liability[a,b]

Reform proposals[c]	Provisions related to increase tax liability
Affordable Health Care Now Act of 1993 (H.R. 3080/S. 1533)	No provision on new tax liability
American Health Security Act of 1993 (HR. 1200/S, 491)	Individual income tax rates increase from 28 to 30 percent, and 31 to 34 percent, with 38 percent being the highest tax rate, Corporate income tax rates increase to 38 percent, Employer Medicare hospital insurance payroll tax Increases from 145 to 7.9 percent, with no cap on wages subject to payroll tax,
Consumer Choice Health Security Act of 1993 (H.R, 3698/S. 1743)	No provision on new tax liablity,
Health Equity and Access Reform Today Act of 1993 (H.R. 3704/S. 1770)	No provision on new tax liablity
Health Security Act (HR. 3600/S, 1757)	Impose a corporate assessment of 1 percent of payroll for corporate alliances. Impose a temporary corporate assessment for businesses with existing retiree health care costs, Increase the excise tax on tobacco products,
Managed Competition Act of 1993 (H.R, 3222/S, 1579)	No provision on new tax liability.

[a] This table includes only specific provisions in the major reform proposals that prescribe an Increase in tax liability and have relatively larger impacts on federal revenues It does not include the implicit assumptions about larger tax bases due to a decrease in insurance premiums

[b] Whether the Insurance premiums paid 10 the federal treasury (e g , the monthly $65 long-term care premium fOr all elderly people under the American Health Security Act) or the regional alliances (e.g , all insurance premiums for the standard benefit package under the Health Security Act) should be considered as taxes has been subject to much discussion Although the Congressional Budget Off Ice does not consider premiums paid under the Health Security Act as "taxes," it does consider premium payments paid to the regional alliances under a mandatory Insurance system as government "receipts"

[c] Proposals are from 103 Congress

SOURCE Off Ice of Technology Assessment, 1994.

TABLE 3-5: Provisions in Selected Reform Proposals That Recover Tax Expenditures Under Current Law[a]

Reform proposals	Provisions related to limiting tax expenditures
Affordable Health Care Now Act of 1993 (HR. 3080/S. 1533)	No provision on recovering current tax expenditures.
Consumer Choice Health Security Act of 1993 (H.R. 3698/S. 1743)	Repeal of current tax exclusions for health Insurance premiums,
Health Equity and Access Reform Today Act of 1993 (HR. 3704/S. 1770)	Limit the tax exclusion of health insurance premiums to a cap equal to the average costs of the lowest priced one-half of qualified health plans.
Health Security Act of 1993 (H.R. 3600/S. 1 757)	After 2004, limit the tax exclusion of health insurance premiums to benefit plans not exceeding the "standard benefit package. " Disallow any health benefits from the tax-exempt cafeteria plans.
Managed Competition Act of 1993 (H.R. 3222/S. 1579)	Limit the employer deduction of health insurance premiums to a cap equal to the lowest priced accountable health plans, Employer contributions exceeding the cap are subject to a 35 percent excise tax.[a]

a An excise tax on employers' contributions in excess of the cap technically is not recovering the tax expenditures recurred under the Current law However, since the provision also represents an effort to limit the tax subsidy of employer-paid health benefits, it is included in the discussion of recovered tax expenditures

[b] Proposals are from 103d Congress.

SOURCE Off Ice of Technology Assessment, 1994

The information required for analysts' estimates depends on the specific approaches used to recover health-related tax expenditures. For example, if the tax subsidy for employer-paid health benefits were limited through a tax cap that treats excess benefits (relative to the tax cap) as employee income, one would need information about the distribution of excess benefits across individuals at different income tax bracket.

A critical issue is the assumption analysts make about how individuals and employers will respond to the proposed tax changes and whether options for other tax-exempt benefits exist. For example, if employers and employees could transfer the taxable health benefits or wages into other forms of tax-exempt compensation, the amount of recoverable tax expenditures would be limited.[10]

I New Tax Expenditures

To achieve various policy objectives, many reform proposals would introduce new or additional tax subsidies for certain health-related spending. For example, many proposals would allow self-employed individuals to deduct their health insurance premiums in full, or make spending for long-term care premiums and contributions to individual medical savings accounts tax deductible.[11] Table 3-6 gives an overview of the provisions that would introduce new tax expenditures.

TABLE 3-6: Provisions in Selected Reform Proposals That Create New Tax Expenditures

Reform proposals[a]	Provisions related to new tax expenditures
Affordable Health Care Now Act of 1993 (H.R. 3080/S 1533)	Raising the tax deductibility of health insurance premiums to 100 percent for self-employed individuals. Tax deductibility of spending for long-term care insurance premiums. Full tax deductibility for medical savings accounts
Consumer Choice Health Security Act of 1993 (H. R 3698/S, 1743)	Income tax credits for health spending. Income tax credits for medical savings accounts.
Health Equity and Access Reform today Act of 1993 (H R 3704/S. 1770)	Raising the tax deductibility of health Insurance premiums to 100 percent for self-employed Individuals, Tax deductibiliy of spending for long-term care Insurance premiums. Full tax deductibility for medical savings accounts.
Health Security Act (H. R. 3600/S. " ***757)***	Raising the tax deductibility of health insurance premiums to 100 percent for self-employed Indviduals. Tax deductibility of spending for long-term care insurance premiums.
Managed Competition Act of 1993 (H. R 3222/S 1579)	Raising the tax deductibility of health insurance premiums to 100 percent (up to the tax cap) for self-employed individuals.

[a] Proposals are from 103d Congress

SOURCE Off Ice of Technology Assessment, 1994

[10] In theory, assumptions about the elasticity of labor supply (i.e., whether people will work more or less as a result of the change in their income taxes) will also need to be considered. That is because, depending on the relative size of the income and substitution effects, wage changes may affect labor supply in many different ways. Federal agencies responsible for budget estimation (e.g., OMB, the Treasury Department, CBO, and JCT) adopted a "constant gross domestic product (GDP)" assumption and required analysts to assume total employment compensation would remain unchanged under reform. By impl ication, the constant GDP assumption would translate into an assumption that labor supply and demand would remain fixed (i.e., near perfect inelasticity with respect to income and price) over the budget period. See appendix B for a more detailed discussion of the "constant GDP" convention used by federal analysts.

[11] Conceptually, medical savings accounts can be viewed as similar to the flexible spending accounts sponsored by many employers. The differences are that funds remain in the flexible spending account at year-end are forfeited and the flexible spending accounts are tied to employment, while the medical savings accounts are not.

The information required to arrive at the estimates of new tax expenditures will depend on the specific type of tax expenditure proposed. For example, estimating the cost of fully deductible health insurance for self-employed individuals depends on three factors: the number of individuals who are self-employed, the respective income tax brackets of the self-employed, and the distribution of additional health insurance expenses subject to tax-exclusion across individuals in different income tax brackets.

Since self-employed individuals currently are allowed to deduct 25 percent of their health insurance premiums, most of the baseline information about self-employed individuals and their health insurance premiums related to tax expenditures presumably is readily available. The critical element that might cause estimates of the tax expenditures to vary is the amount of additional health insurance expenses subject to tax exclusion, which in turn depends on analysts' estimates of the premium levels and premium growth rates under reform.

Estimates of lost revenues from other sources of tax expenditures are likely to be subject to greater uncertainty than the estimates of tax expenditures resulting from the self-employed tax deductibility provision. For example, estimates for the tax expenditures associated with the tax-exempt individual medical savings accounts would depend mainly on: the amount of savings being put into those accounts, and the number of medical savings accounts across different income tax rate groups (i.e., the participation rate).

Since individual medical savings accounts do not exist under current law, analysts may use the experience of other programs, such as individual retirement accounts or flexible spending accounts, to infer the participation rate and amounts of potential savings in the medical savings accounts programs. However these programs differ from medical savings accounts. For example, since funds remain in the flexible spending account at year-end are forfeited, and not all employers provide the flexible spending accounts, the participation rate and level of flexible spending accounts may understate both the participation and the magnitude of savings for medical savings accounts.

Similarly, estimates of additional tax expenditures for the favorable tax treatment of long-term care insurance premiums will be affected by the costs and participation across individuals at different income tax brackets. These estimates also have to take into account the potential inducement effects on the demand for such insurance as well as on the utilization of related services. Since analysts may differ in their assumptions about the demand of such insurance, estimates of the related tax expenditures are likely to vary too.