Impacts on Federal, State and Local Budgets

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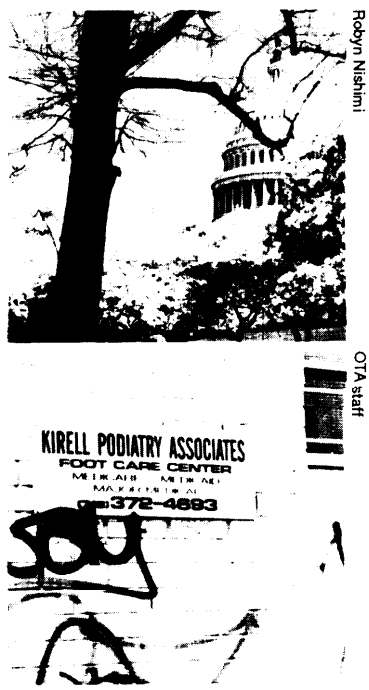
INTRODUCTION

Federal, State and local governments contribute directly to the financing of health care through payment for public health insurance[1] programs (e.g., Medicare, Medicaid, CHAMPUS[2]) and public health programs (47). They also make an indirect contribution through tax policy, e.g., the exclusion of employer contributions to workers' health care benefits from employee taxable income (Internal Revenue Code of 1986, §§105 and 106); the personal deduction for a specified portion of health insurance premiums paid by self-employed individuals (Internal Revenue Code of 1986, §162 (1));[3] the Schedule A deduction from personal income of a portion of medical expenses over a specified proportion of adjusted gross income (Internal Revenue Code of 1986, §213); and the supplemental health insurance credit component of the earned income tax credit (Internal Revenue Code of 1986, §32). The Joint Committee on Taxation, U.S. Congress, projects that the tax expenditures associated with the tax exclusion, Schedule A



Robyn Nishimi

OTA staff

[1] The term "health insurance" is used broadly to include various types of health plans that are designed to reimburse or indemnify individuals or families for the costs of medical care, or (as in HMOs) to arrange for the delivery of that care, including traditional private indemnity fee-for-service coverage, prepaid health plans such as health maintenance organizations, self-funded employment-based health plans, Medicaid, and Medicare.

[2] *CHAMP*US is the Civilian Health and Medical Program of the Uniformed Services.

[3] This tax code provision expired June 30, 1992. Legislation has been introduced in the 103d Congress to extend the deduction and to increase it to 100 percent of premiums paid (e.g., H.R. 162, H.R. 815, S. 381, and S. 571, all bills to amend the Internal Revenue Code of 1986).

[4] "Tax expenditures," as defined by the Congressional Budget and Impoundment Act of 1974, are "reductions in individual and corporate income tax liabilities that result from special tax provisions or regulations that provide tax benefits to particular taxpayers. These special tax provisions can take the form of exclusions, credits, deductions, preferential tax rates, or deferrals of tax liability" (86).

deduction, and supplemental health insurance credit will be $36.7 billion, $3.5 billion, and $.1 billion, in 1994, respectively (86).

The Congressional Budget Office projected that the government share of national health expenditures for 1992 would be 45.5 percent of total national health expenditures (79). Among levels of government, CBO projected the Federal Government's share to be 31.3 percent, and the State and local governments' share to be 14.2 percent. CBO estimates did not include the value of the aforementioned tax subsidies. Steuerle has estimated that in fiscal year 1992, Federal, State and local governments would pay more than one-half ($390.0 billion) of total health care expenditures in the United States (72). Unlike the CBO estimates, Steuerle's estimate *included $63.0 billion in* Federal tax subsidies, which, as indicated above, operate like other expenditures to the extent that they represent revenues forgone by government (72).

According to the Employee Benefit Research Institute, the government share of national health care expenditures has been fairly constant since the implementation of Medicare and Medicaid, but the share of government budgets devoted to health care has increased as budgets have been tightened but government health care funding responsibilities have not declined (14). Therefore, in addition to the impact of any health care reform approaches on aggregate (national) health expenditures as defined in chapter 2 of this report, at issue in the health care reform debate are:

- the extent to which alternative reforms might increase or decrease governments' share of health care spending; and
- the potential for redistributing the burden of financing among Federal, State and local government.

IMPACTS OF SINGLE PAYER APPROACHES

Proposals that would make the government the sole purchaser of health care services essentially redistribute the responsibility for purchasing health care services from a diverse group of purchasers to government. The proportion of this responsibility funded through Federal, State and local government revenues can vary, as can the means by which governments collect the revenues, that is, the types of taxes levied, to finance this burden. Regardless of how governments obtain the necessary funds, governments would bear tremendous responsibility for direct funding of, and control over purchasing, health care services in such a system.

Estimates of the impact of a Single Payer system on government budgets cover a wide range, from relatively modest *increased government spending in the* first year ($29.0 billion in 1991) with the promise of unspecified *savings* after the third year (43), to *large initial outlays* by government ($252.0 billion in 1991) (25) (table 2 in chapter 1; also see appendix B).

While no one maintains that Federal, State and local governments would save money initially under a Single Payer system, its long-term impact on government budgets is not clear, and quantitative estimates of the cumulative impact of a Single Payer system on government budgets were not provided in the studies reviewed. Assumptions about the degree to which a Single Payer system will control the rate of growth in health care spending greatly influence the long-term budgetary impact of the approach. For example, one group of analysts assumed that total health care spending would not exceed 8.7 percent of GDP (43). Another analysis assumed that national health care spending would continue to grow at about 10 percent each year under a Single Payer system (25). These assumptions help greatly to explain why one group of analysts expects government to save money on health care after 3 years (43).

Tax increases would be necessary to raise the revenues for governments to fulfill their obligations; however, it is likely that other sectors of the economy would realize gains (e.g., a decrease in or elimination of premiums paid to private

insurers) although these may be offset, at least in part, by such increased taxes. Proponents assume that the Single Payer system funded by taxes would result, nevertheless, in a more equitable distribution of health care spending.

IMPACTS OF PLAY-OR-PAY APPROACHES

The effect on government budgets of employment-based approaches that incorporate a public backup plan appears to depend primarily upon:

- the number of people enrolled in the public plan; and
- whether Federal and State Medicaid funds, and revenues from employment settings earmarked for the public plan (e.g., payroll taxes), are sufficient to cover the cost of insuring the public plan's enrollees and to fund any government subsidies under the plan.

Both the number of people enrolled in the public plan and the level of revenues required to fund the plan appear to be functions of numerous factors: employers' behavior (e.g., whether they choose to sponsor private insurance or contribute to the public fund to cover their employees); types of employers and employees covered by the employer mandate; the cost of health insurance; the payroll tax rate; employer/employee premium cost-sharing; public plan enrollee premium cost-sharing, if any; and the nature and extent of public subsidies (e.g., to small employers, to low-income persons).

While the employment-based approach places the bulk of the direct burden of financing health care coverage on employer-sponsored groups, it could increase direct and indirect outlays for health care at all levels of government (76). First, to the extent that the approach increases access to employment-based coverage without modifying the tax treatment of health benefits, tax revenues under current policy would be reduced by increasing the number of persons with respect to whom the employer deduction/employee exclusion would apply (76). Should the tax exclusion be limited, however, governments may expect some increased revenues flowing from increased personal and corporate income taxes. Second, Play-or-Pay approaches would shift any uninsured and individually insured persons not eligible for employment-based health coverage to the public plan, although some of these persons are expected to contribute directly to the cost of their coverage. To the extent that projected total funding of the public plan is adequate to cover both the cost of insuring its enrollees and the cost of required subsidies (e.g., to small employers, to low-income persons), the impact on government budgets would be lessened but costs to business and individuals would likely increase.

None of the analyses projected initial *savings* to governments overall from a Play-or-Pay approach, but one analysis estimated *savings* to State and local governments in the amount of $7.4 billion in 1990 at the same time it projected increased spending by the Federal government (75) (table 2 in chapter 1). Estimates of initial *increased spending* by governments resulting from an employment-based approach range from $16.6 billion (in the **year** 1990) (75) to $41.7 billion in 1993 (37). Several other estimates fall between these two extremes (49,76,100). Cumulative estimates were not available.

The above estimates at the extremes of the range of impacts of the Play-or-Pay approach on government budgets assumed that States support the public plan in the same proportion as their current level of contribution to Medicaid (37,75). And neither assumed that the cost-containment measures included in each plan would be effective in the first year of plan implementation. While the payroll tax rate selected will affect the magnitude of government spending (100), it appears that a plan's cost-containment measures will have a greater impact on the growth in government spending (55).

IMPACTS OF APPROACHES EMPLOYING INDIVIDUAL VOUCHERS OR TAX CREDITS

For the most part, proposals that involve the use of individual vouchers or tax credits to expand coverage are specifically intended not to result in significant additional spending on the part of government. Analyses of the impact of such proposals suggest that a major assumption with respect to plans providing tax deductions, credits or vouchers is that a minimum benefit plan will be available for the dollar amount of the credit or voucher for those eligible for the maximum amount of assistance, and that the deduction will be adequate to make coverage affordable for the eligible population.

Lewin-VHI's analysis of the Heritage Foundation's individual voucher/tax credit proposal, executed on behalf of the Foundation, indicated that $87.9 billion in Federal funds and $7.6 billion in State funds would be necessary to implement the plan in 1991 (35) (table 2 in chapter 1). Specific estimates of the Bush Administration plan on government budgets were not available.

The Heritage Foundation's plan asserted, however, that the plan would be revenue neutral, that is, it would be fully funded at the Federal and State levels, and have no effect on the Federal deficit. To accomplish this, the analysis assumed that tax code modifications, in particular, would raise most of the funds necessary for the plan's implementation. Thus, the $87.9 billion in Federal funds necessary to implement the plan in 1991 would be raised through the elimination of the tax exclusion for employment-based premiums and of the deduction for health expenditures in excess of 7.5 percent of adjusted gross income, and from savings to State and local governments passed onto the Federal Government to fund the tax credits. State and local governments would be similarly affected by the proposal, as a result of transferring their savings of $18.8 billion to the Federal Government for the tax credit plan, as indicated above. State and local government total savings would be derived from several sources: the elimination of the State income tax exclusion; decreased expenditures on public hospitals offset to some extent by increased State and local workers benefits; and decreased revenues resulting from changes in premium taxes and State corporate income taxes.

IMPACTS OF MANAGED COMPETITION APPROACHES

Although Managed Competition is an approach that some say is consistent with several methods of financing (70,71), most Managed Competition approaches seek to minimize the role of governments in providing health care coverage, at least relative to tax-financed Single Payer approaches. Most approaches calling themselves Managed Competition would retain and/or build upon the current employment-based system, require individuals to contribute to the cost of their coverage to the extent possible, and mod@ the tax treatment of employer-sponsored coverage, thereby decreasing Federal tax expenditures associated with health insurance premiums. Thus, estimates of the impact on government budgets of Managed Competition approaches may depend upon assumptions about such interrelated factors as: the extent of public subsidies for coverage; the premium for the lowest-cost plan and any change in the tax policy regarding employer-sponsored benefits; the content of the standardized benefit package; whether there is an employer mandate; and recoupment of funds presently used to fired indigent care.

Estimates of the impact of Managed Competition approaches on government budgets range from $31.0 billion in total net new Federal revenues in 1993 (40) to $106.5 billion in Federal expenditures in 1994 (10) (table 2 in chapter 1). The estimate of $106.5 billion in Federal expenditures was, however, expected to be completely offset by revenues from Federal Medicaid funds; a cap, operationally, on the tax deductibility to employers of health insurance benefits; and the repeal of the taxable maximum income for

Medicare benefits. This would result in Federal budget neutrality, if all estimates of new spending and increased revenue were correct (10).

The variance in these estimates may ensue at least in part from major design differences between the proposals analyzed. That is, the Conservative Democratic Forum's (CDF) proposal did not include an employer or employee mandate nor did it modify the employee tax exclusion for employer-sponsored premiums (lo).

The Managed Competition plans analyzed by Sheils and his colleagues (63), and Long and Rodgers (40), differed substantially from the CDF'S proposal. Sheils and his colleagues based their estimates loosely on Paul Starr's version of Managed Competition, which assumes an employer mandate with a public backup and, thus, universal coverage (71). Long and Rodgers used many of the same numbers as Sheils and his colleagues, but varied some assumptions in order to answer three broad questions, including one about the impact of the approach on government budgets (40).

Long and Rodgers point out that Sheils and his colleagues did not indicate how much of the net new costs to the Federal Government would arise from savings from Managed Competition. As noted in table 2 in chapter 1, Long and Rodgers' three estimates of net new government costs were based on three illustrative scenarios: 1) no savings from Managed Competition; 2) 8 percent savings from either managed care or administrative-costs savings; or 3) 16 percent savings from adding together projected managed care savings and projected administrative costs-savings.

In their article, Sheils and his colleagues had assumed 2 percent savings resulting from increased use of managed care arrangements.[5] They also pointed out that their estimates may have understated potential savings because they were not able to fully explore the possible dynamics of Managed Competition (e.g., potential savings that concentrated buying power would have on the unit cost of services provided; incentives to contain costs even for HMOS by increasing consumers' price sensitivity and eliminating risk selection as a means of maximizing insurers profits) (63). On the other hand, no one--including CDF—seems to have built into their estimates of the impact of Managed Competition the full costs of administering all the new quasi-governmental bodies and disseminating all the information that appear to be an important part of Managed Competition (57). Some of these will undoubtedly be new costs to governments. Long and Rodgers' estimates thus illustrate how sensitive projections can be to variations in critical assumptions.

SUMMARY

None of the analyses reviewed for this report estimated savings to governments from the implementation of any one of the approaches to health care reform addressed. Efforts to expand access to uninsured persons will necessarily entail some new government spending since some form of subsidy will be necessary for many of these people and, in some proposals, for their employers. The Single Payer approach, as a tax-financed system, relies more on government to make direct payments for coverage and services as compared

[5] In an article in the same journal, Staines, an analyst with the Congressional Budget Office, suggests that national health spending might be almost 10 percent lower if all acute health care services were delivered through staff-or group-model HMOs (68). He further estimates that universal use of utilization review, managed care arrangements might result in spending that is only 1 percent lower than current national health expenditures (68). Sties did not estimate how much of these savings would accrue to the Federal Government under alternative health care reform plans. However, Staines' estimates suggest that Sheik and his colleagues' estimates differed from Long and Rodgers' estimate of changes in national health expenditures, and the subsequent distribution to the Federal Government of combining Managed Competition and Play-or-Pay, because of their differing ideas about the nature of managed care under Managed Competition. The extent to which staff- or group-model HMOs will be able to deliver health care---and achieve savings-should Managed *Competition become the* approach pursued for health care reform is a critical issue in the debate.

with the other approaches. Therefore, it is the approach most likely to increase government spending for health care. Yet the redistributive effects of this, or any other approach, on other areas of the economy (e.g., impacts on households) should be reviewed carefully, in order to evaluate any offsetting effects. Government budgets, in absolute terms, will be affected by the rate of growth in national health expenditures. Thus, the extent to which cost-containment is incorporated in an approach will be important to the impact of health care reform on such government budgets, regardless of the approach adopted.