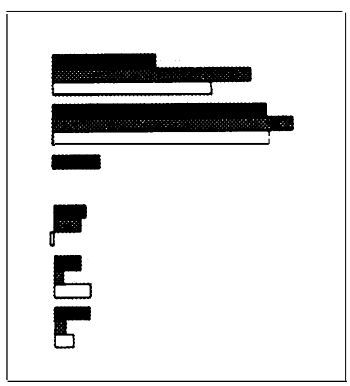
Summary 1

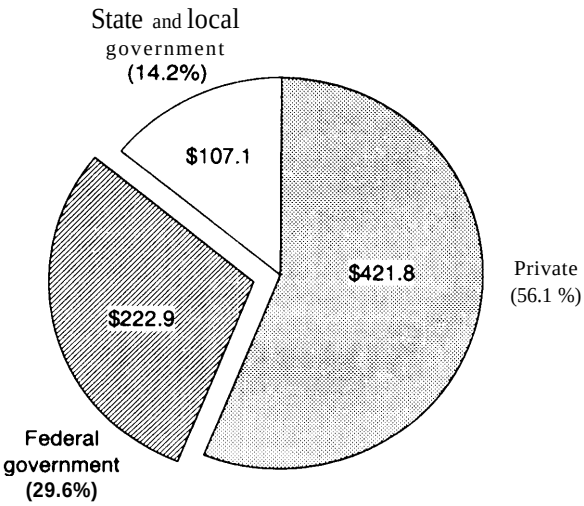
Currently, in the United States, the federal government directly finances various health insurance programs, such as Medicare, Medicaid, and CHAMPUS—the Civilian Health and Medical Program of the Uniformed Services. The government also indirectly finances the purchase of medical care and private health insurance through various forms of tax expenditures, such as the exclusion of employer-sponsored health benefits from the employees' taxable income.[1] In 1991, spending for all health programs constituted approximately 14 percent of the total $1.3 trillion in federal outlays (10,32,46). CBO has projected that, under current law, in 1998, federal spending for health will constitute 23.6 percent of total spending by the federal government (32).

Estimates of the effect of the health reform on the federal budget are an important part of the current health reform debate. Yet different analysts' estimates are not always in agreement and questions remain about the certainty of all of the estimates.



[1] *Tax* expenditures, as defined by the Congressional Budget and Impoundment Act of 1974 (Public Law 93-344), 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." Examples of health care related tax expenditures prescribed by the Internal Revenue Code include: the exclusion of employer contributions to workers' health care benefits from employee taxable income (sections 105 and 106), the personal deduction of a specified portion of the health insurance premium paid by self-employed individuals (section 162), and the Schedule A deduction from personal income of a portion of the medical expenses over a specified proportion of adjusted gross income (section 213).

FIGURE 1-1: National Health Expenditures by Source of Funds, 1991 ($ billions)



SOURCE S W Letsch, H C Lazenby, K R Levit, et al , "National Health Expenditures, 1991 ," Health *Care Financing Review* 14(2). 1-30, 1992

This Office of Technology Assessment (OTA) background paper describes three estimates—by the Congressional Budget Office (CBO), Lewin-VHI, and the Clinton Administration-of the budget impact of the Health Security Act. The paper examines the major differences in analysts' estimates and the reasons for those differences.[2] The paper also describes more generally why estimates of health reform proposals might differ.

This background paper is published as part of the OTA's study *Understanding the Estimates Under Health Reform. The* study was requested in August **1993** by OTA's Technology Assessment Board and Senator Ted Stevens.

In a separate OTA report, *Understanding Estimates of National Health Expenditures Under Health Reform (45),* OTA examined estimates of the impact of various health care reform proposals on national health expenditures, as well as the assumptions behind the estimates. The effects of the reform proposals on the federal budget may not necessarily parallel their intended effects on national health expenditures. Specific provisions in the reform proposals may increase or decrease federal spending and receipts, independent of their effects on national health expenditures. As shown in figure 1-1, federal spending accounted for about 30 percent of the national health expenditures in 1991.

This paper does not compare or evaluate different reform proposals, nor does it provide new estimates of the effect of health reform on the federal budget.

KEY FINDINGS

I Major Areas of Difference in Estimates

Thus far, much policy discussion has focused on the aggregate "bottom line" estimates of health reform's impact on the federal budget. For example, the Clinton Administration projected that the Health Security Act would reduce the deficit by $58.5 billion, from 1995 through 2000. Lewin-VHI projected a much lower reduction of $24.6 billion. The Congressional Budget Office (CBO), by contrast, projected that the federal deficit would increase by $74 billion. In fact, these estimates of the aggregate budgetary effects may actually overstate the degree of consistency across analyses. Significant disparities may exist on the budgetary effects of certain reform provisions and these differences may be offsetting, thus agreement on the "bottom line" estimates may provide a false sense of consistency and certainty. This

2 OTA chose t. examine these three particular analyses because they provide separate estimates for specific budget items, not just an aggregate "bottom line" estimate. and OTA has relatively more information regarding the general methods used by these analysts. In addition, this is one of the relatively rare instances where analysts provide estimates for the same legislation. This condition is critical because estimates of federal budget impacts under health reform are sensitive to the specific provisions in the legislation. KPMG Peat MarWick, a private consulting firm, published its analysis of the Health Security Act on March 28,1994. OTA did not include the KPMG estimates in its analysis because they were not available until after OTA had completed its draft report. In addition, the KPMG analysis provided relatively less information regarding its estimates.

background paper evaluates the estimates of each of the bills' major provisions separately.

Figure 1-2 depicts the provisions in the Health Security Act (H. R.3600/S.1757) that differ the most across the various estimates.[3] The differences between the Clinton Administration, CBO, and Lewin-VHI's "bottom line" estimates of the federal budget effects of the Health Security Act result mainly from analysts' estimates of the following four specific budget items that differ most in absolute monetary terms:

- Costs of employer and family premium subsidies, especially subsidies for employers. In absolute terms this represents an area where analysts' estimates disagree most.[4] Lewin-VHI's and CBO'S estimates of the employer subsidies are 54 and 92 percent higher (respective y) than those of the Clinton Administration (nearly $50 billion and $86 billion higher, respectively, than the $93.1 billion projected by the Clinton Administration for period from 1995 through 2000). However, the Clinton Administration added a 15 percent contingency, equal to $41.2 billion, to the estimates of the premium subsidies. The Clinton Administration used the 15 percent as a "cushion" to cover potential behavioral responses that it believed difficult to model. The three estimates would be closer if the cushion were included (see Chapter 2).
- Potential revenues gained from the additional income and payroll taxes resulting from lower health care expenses and higher income due to universal coverage, subsidies, and cost containment. CBO'S estimates are only about 16 percent lower than the Clinton Administration's ($24 billion versus $28.4 billion for the period from 1995 through 2000), but Lewin-VHI'S estimates are 113 percent lower (i.e., Lewin-VHI projected a revenue loss, not gain, of $3.7 billion).
- Potential revenues gained from recovered tax expenditures by excluding health benefits from cafeteria plans. CBO'S and Lewin-VHI's estimates of these revenues are 68 and 46 percent lower, respectively, than those of the Clinton Administration ($10 billion and $17 billion versus $31.4 billion for the period from 1995 through 2000).
- Potential revenues gained from the 1 percent payroll tax for corporate alliances. CBO'S estimates are 67 percent lower than those of the Clinton Administration ($8 billion versus $24.2 billion for period from 1995 through 2000), while Lewin-VHI's estimates are 36 percent higher than the Clinton Administration ($33.0 billion versus $24.2 billion).

In general, CBO'S estimates of the Health Security Act tend to generate higher figures for expenditure items, and lower figures for revenue items than those of the Clinton Administration. Fewer consistent differences exist between the Lewin-VHI and the Clinton Administration estimates.

Determinants of the Difference in the Estimates[5]

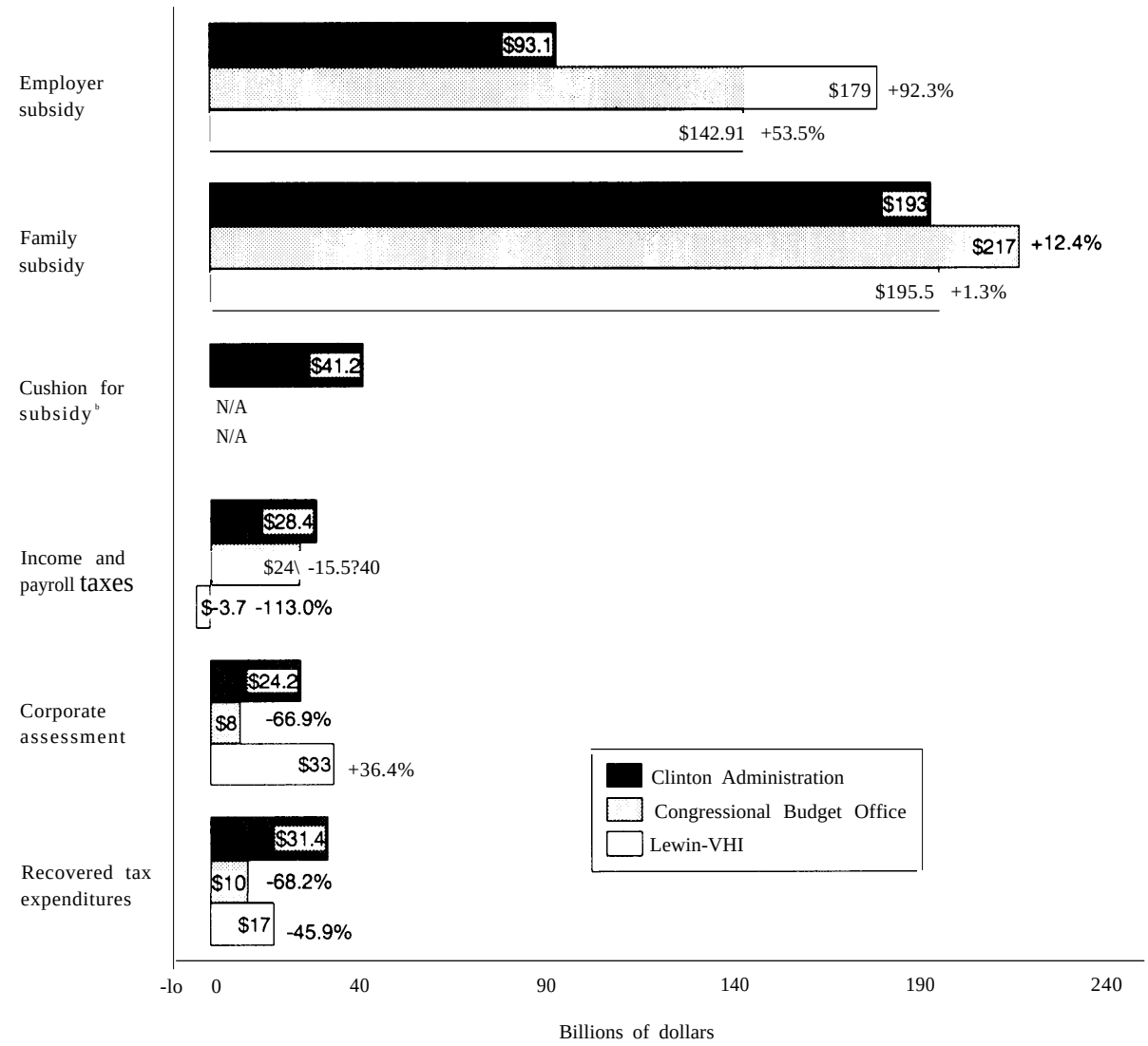
OTA found that inconsistencies between analyses often indicate that the data and research evidence necessary to make accurate predictions are lack-

[3] There are many ways to define the areas of greatest disparity across the estimates (e.g., in terms of absolute or relative terms), and the differences will depend on whose estimates are being compared. These areas were found to differ most in absolute terms when all possible comparisons are considered (i.e., CBO vs. the Clinton Administration, CBO vs. Lewin-VHI, Lewin-VHl vs. the Cl inton Administration). All the provisions identified differed by more than $20 billion (between at least two organizations).

[4] For example, differences in the estimated cost of the subsidies for employers account for approximately half the total difference between CBO's and the Administration's estimate.

[5] Since analysts typically do not publish information on the specific input parameters and algorithms (i.e., the basic calculation steps) used in their analyses, it is extremely difficult to assert with complete certainty what has contributed to the differences in analysts' estimates. OTA's analysis is based on its understanding of the general methods used by various analysts and analytically infers the major factors that may have contributed to the differences in estimates. This background paper was sent to the relevant analytic organizations for review.

FIGURE 1-2: Major Areas of Difference in Estimates of the Health Security Act (H.R. 3600/S. 1757), 1995-2000[a]



[a] The percentages shown in the figure are the differences relative to the Clinton Administration's projections.

[b] Note that the Clinton Administration's estimates for subsidies do not include the potential behavioral responses to the subsidies The Clinton Administration uses a separate "cushion" to cover the behavioral responses to subsidies. Neither CBO nor Lewin-VHI adopted such methodology in their estimates of the subsidies

SOURCE Off Ice of Technology Assessment, 1994

ing. Differences across estimates may also result from the nature of the legislation being estimated. Some legislation may not be specific enough to allow for exact and consistent estimation. In contrast, inconsistencies did not indicate that analysts' methods were incorrect or biased.

Table 1-1 summarizes the major factors that have contributed to the differences in analysts' estimates of various provisions under the Health Security Act. The factors fall into three major categories:

- Analysts estimates of the premiums for standard benefit packages under the regional alliances.
- Analysts' assumptions about behavioral responses to specific reforms. These include assumptions about individual and employer responses to changes in premiums (e.g., whether employers will opt for corporate alliances), to premium subsidies (e.g., whether employers will set up small low-wage subsidiaries to maximize the premium subsidies), and to changes in the tax treatment of health benefits (e.g., whether individuals will prefer tax-exempt benefits over additional wages).
- Baseline information on numerous household and firm-level economic variables. For example, information on the distribution of average payroll and employer spending on health benefits by firm size, and the distribution of medical expenses by household income, are essential for estimating the premium subsidies.

TABLE 1-1: Major Determinants of Differences in Estimates of the Health Security Act (H.R. 3600/S. 1757)

Federal budget-related provisions	Factors accounting for differences in estimates
Expenditures for family and employer subsidies	Premium level and growth Baseline estimates of families and firms eligible for subsidies Behavioral responses to premium subsidies
Expenditures for Medicare drug benefit	Baseline expenditures for prescription drugs among beneficiaries Additional demand due to the benefit coverage Participation rate among eliglble beneficiaries
Expenditures for long-term care benefit	State spending on optional Medicaid services
Savings from Medicare and Medicaid	Growth rates of Medicare and Medicaid baseline expenditures Decreased demand for certain services due to cost-sharing
Taxes on corporate and personal income	Baseline spending on health benefits and health care Estimated spending on health benefits and health care under Teform
Taxes on tobacco products	Baseline expenditures on tobacco products Reduction in tobacco consumption due to higher taxes (i.e., elasticity of demand)
Assessment for corporate alliances	Participation rate of corporate alliances Baseline employer spending on health benefits Estimated employer spending on health benefits under reform
Recovered tax expenditures (from cafeteria plan provision)	Baseline tax expenditures associated with health benefits under cafeteria plan Behavioral responses to changes in income tax code

SOURCE Office of Technology Assessment, 1994

[6] In this background paper, the term baseline means the state of the system before any proposed policy change or reform. It is a benchmark for measuring the effects of the proposed policy changes. It can refer to the expenditures, the demographic compositions, or the underlying macroeconomic factors that are generally used as the input parameters in estimating the effects of reform.

Both CBO and Lewin-VHI projected higher premiums than the Clinton Administration. Higher premium estimates will lead to higher subsidy estimates. In part, the difficulty in estimating the premiums is a product of the multiple sources of financing for people currently without insurance. For example, under the current system services used by people without insurance are partially financed through cost-shifting to private health insurance premiums. Analysts differ in their estimates of the size of uncompensated care and of the effect that eliminating uncompensated care will have on premiums. Differences also reflect a lack of consensus over the appropriate data for pricing benefits (e.g., the national health accounts or private health insurance claims data) and over the effect of HMOs on premiums.

Analysts' assumptions about the behavior of individuals and employers under reform also contributed to the differences in the estimates. For example, as the premiums for the standard benefit package under regional alliances increase and become more burdensome to employers, employers may be more likely to find ways to meet the eligibility criteria for the subsidy program (i.e., to "game" the system). However, analysts differ in their assumptions about the magnitude of such responses and, at this time, no good evidence exists on how employers will respond to the incentives inherent in the subsidy program.

In some cases differences across the estimates resulted from a lack of data on certain key elements necessary to arrive at the estimates, or from a lack of consensus about the appropriate data sources. OTA's review of various estimates suggests that data on expenditures and utilization in public health insurance programs are usually readily available. However, there is no consensus about the appropriate sources of data for expenditures in private-sector fins, such as the distribution of average payroll and health benefits by firm size. To date, the federal government has collected health-related data primarily through household surveys.[7] Better firm-level data maybe warranted if health care reform is to be built upon the existing structure of employment-based private health insurance.[8]

ORGANIZATION OF THE REPORT

This introductory chapter provides a summary of the findings about major areas of disparity, and the determinants that may account for those differences, across various estimates of the federal budget effects of the Health Security Act. Chapter 2 uses various estimates of the Health Security Act to illustrate how estimates of federal budget effects of health reform might differ and the factors most likely to contribute to the differences in analysts' estimates. The discussion focuses on three different estimates of the Health Security Act, by the Clinton Administration (51), CBO (38), and Lewin-VHI, a private health care consulting firm (13).

Chapter 3 describes more generally how federal expenditures and receipts are likely to be affected by reform provisions that seek either to expand or limit the federal government's presence in the health care sector. The main objective of chapter 3 is to identify, more generally, relevant determinants and assumptions that are most likely

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7 Within the U.S. Public Health Service, *the* National Center for Health Statistics (NCHS) is currently coordinating a National Employer Health Insurance Survey cosponsored by the Health Care Financing Administration and the Agency for Health Care Policy and Research. The survey, which will sample a nationally representative 51,000 establishments, is designed to be representative of employers in the nation, as well as by region, state, standard industrial classification, and size. The data are scheduled to be publicly available by 1995 (26).

8 There are currently some firm-level data on employment-based health insurance and benefits from numerous private sector trade associations and benefit consulting firms. For example, before 1993 the Health Insurance Association of America conducted an annual survey of employer-sponsored health benefits. Major benefit consulting firms, such as Hay/Huggins, A. Foster Higgins, and KPMG Peat MarWick, all have their own annual health benefits survey of various size of employers. However, there are some weaknesses (e.g., representativeness of the sample design, inadequacy of the instrumentation, low item response rate) in these survey data that limit their reliability and accuracy in estimating the effects of employer premium subsidies (26).

to affect analysts' estimates for major categories of federal outlays and revenues under health care reform.

Chapter 4 provides a brief review of CBO's estimates for the American Health Security Act (H.R. 1200/S.491) and the Managed Competition Act of 1993 (H. R.3222/S.1579), and discusses areas that are likely to be subject to some uncertainty in the estimates. Finally, since the federal budget process largely affects how executive and congressional agencies estimate the impact of statute changes, a general description of the process is included as appendix B. Appendix C provides an overview of the data sources analysts generally use to derive the necessary baseline information about insurance coverage, health expenditures, employment and income, and demographic compositions, which are essential for their estimates.