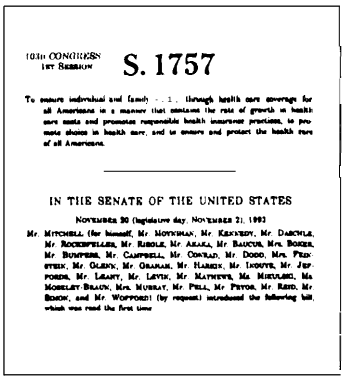
Estimates of the Health Security Act

2

Estimates of different reform provisions present different challenges for analysts. In some cases, estimates of the effect of certain reform provisions on the federal budget are relatively straightforward because only a few factors are necessary for estimates and good data and research exist on critical inputs and assumptions. In other cases, the estimates are complicated by the large number of factors involved, the scarcity and quality of data, and the lack of information on behavioral responses to various changes under the reform. Under such circumstances, analysts often have to make subjective or somewhat uncertain assumptions in the estimation process. Differences in assumptions and data sources are often the major reason why analysts' estimates differ. Although different methods of estimation may also lead to variations in estimates across analysts.

This chapter reviews various estimates of the Clinton Administration's Health Security Act to examine in more detail how and why analysts' estimates differ. The Health Security Act has various provisions that would affect both government spending and receipts, and therefore serves as a useful example of how health reform might affect the federal budget. [1] The chapter will describe three much-discussed estimates of the act: by the Clinton Administration (50,51), by the Congressional Budget Office (CBO) (38), and by Lewin-VHI (13), a private consulting firm.



103D CONGRESS
1ST SESSION

S. 1757

To ensure individual and family ... through health care coverage for all Americans in a manner that contains the rate of growth in health care costs and promotes responsible health insurance practices, to promote choice in health care, and to ensure and protect the health care of all Americans.

IN THE SENATE OF THE UNITED STATES

NOVEMBER 20 (legislative day, NOVEMBER 21, 1993

Mr. MITCHELL (for himself, Mr. MOYNIHAN, Mr. KENNEDY, Mr. DASCHLE, Mr. ROCKEFELLER, Mr. RIEGLE, Mr. AKAKA, Mr. BAUCUS, Mrs. BOXER, Mr. BUMPERS, Mr. CAMPBELL, Mr. CONRAD, Mr. DODD, Mrs. FEINSTEIN, Mr. GLENN, Mr. GRAHAM, Mr. HARKIN, Mr. INOUYE, Mr. JEFFORDS, Mr. LEAHY, Mr. LEVIN, Mr. MATHEWS, Ms. MIKULSKI, Ms. MOSELEY-BRAUN, Mrs. MURRAY, Mr. PELL, Mr. PRYOR, Mr. REID, Mr. SIMON, and Mr. WOFFORD) (by request) introduced the following bill, which was read the first time

[1] So far, the Clinton Administration's Health Security Act has received the most publicly available program-specific analyses of its federal budgetary effects.

Much attention has focused on the Clinton Administration's estimate that the Health Security Act would reduce the federal budget deficit by $58.5 billion, while Lewin-VHI projected a much lower reduction of $24.6 billion, and CBO projected that the net effect would be a deficit increase of $74 billion from 1995 through 2000. It should be noted, however, that estimates of the aggregate budgetary effects may overestimate the degree of consistency across analyses. Analysts can come up with different estimates of specific reform provisions, but arrive at similar aggregate budgetary effects. For example, an analysis with relatively higher estimates of both federal expenditures and revenues may have the same aggregate level budgetary impact as any analysis with relatively lower estimates for both expenditures and revenues.

The analysis in this chapter will be organized around the specific reform provisions in the Health Security Act. Since the Health Security Act contains a relatively large number of reform provisions that will directly or indirectly affect federal outlays and receipts, the discussion will focus on three major areas of federal outlays:

- expenditures associated with employer and family subsidies;
- expenditures associated with Medicare prescription drug benefits and the long-term care program for severely disabled individuals; and
- savings from Medicare and Medicaid.

It will also focus on three major areas of federal' revenues:

- new taxes on tobacco products, additional revenue from income and payroll taxes, taxes on corporate alliances and an early retiree assessment;
- recovered tax expenditures from limiting the tax exclusion of health benefits; and
- revenue loss from new tax expenditures associated with the tax deduction for self-employed health insurance premium.

Estimates for other reform provisions such as the various public health initiatives, new administrative and start-up functions and savings from the VA, the Department of Defense, and federal employee health programs that will also affect federal outlays and receipts are not examined in detail. The choice of specific reform provisions discussed in this report is based on the relative size of the expenditures or revenues involved. The provisions reviewed make up more than 85 percent of the estimated federal budget effects (both in terms of additional outlays and revenue). Figure 2-1 provides an overview of analysts' estimates of the act's major reform provisions.

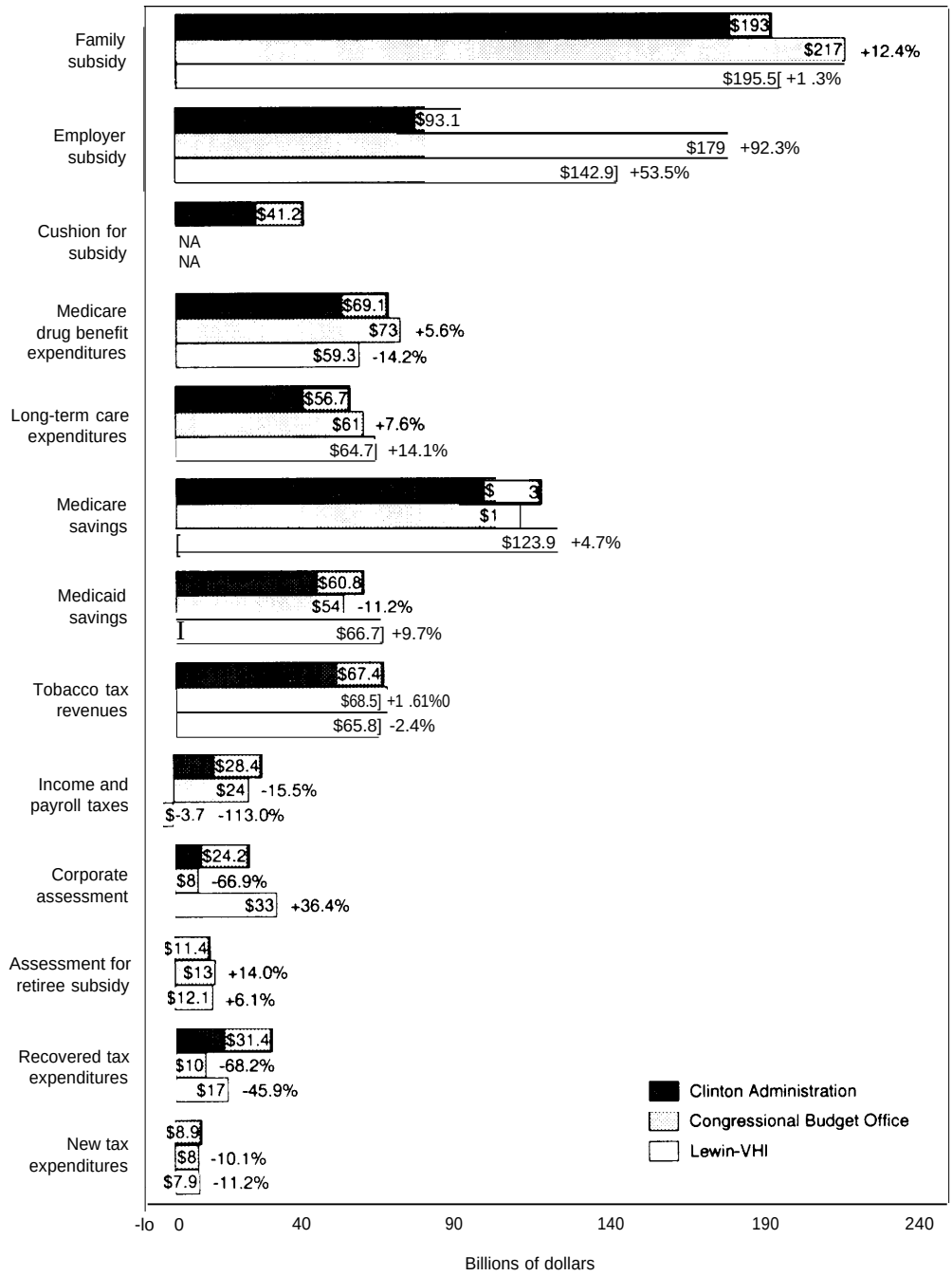
SOURCES OF INFORMATION

Since the introduction of its health care reform proposal in September 1993, the Clinton Administration has released four major documents depicting its estimates of the effect of the Health Security Act on the federal budget.

The Health Security Act of 1993: Documentation of Federal Budget Effects (50), released by the Office of Management and Budget (OMB) in December 1993, provided estimates for all major reform provisions that affect federal spending. Based on the same expenditure estimates, Rivlin, Cutler, and Nichols, all officials of the Clinton Administration, published an article, "Financing, Estimation, and Economic Effects," in the spring 1994 issue of *Health Affairs (* 18). The article provides the same set of estimates as the December 1993 OMB document, but it contains additional discussion of the general methodology that the Clinton Administration used to arrive at its estimates.[2] Additionally, the Office of Tax Analysis in the Treasury Department also prepared a docu-

2There is also various Congressional testimony by Clinton Administration officials regarding the projections and financing issues. All of the testimony relied on the same set of expenditure estimates, which appeared in the December 1993 OMB documentation, and they will also be referred to as the Clinton Administration's December 1993 estimates.

FIGURE 2-1: Projections of Federal Budget Effects Under 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

KEY NA = not applicable

SOURCE Office of Technology Assessment, 1994

ment, Estimating the Impact of Health Reform on Federal Receipts, describing the general methodology used by the Clinton Administration in its estimates of the revenue effects under the Health Security Act (49).[3]

Another document containing the Administration's most recent estimates was the FY1995 budget proposal, *Budget of the U.S. Government, FY95 (51).* Because the underlying assumptions about the future of the economy and related factors used in the Clinton Administration's estimates were changed between December 1993 and February 1994, there are some differences in the Clinton Administration's two estimates of the federal budget effects of health reform.[4] The revision is an example of how an overall estimate may change due to new projections of inflation, interest rates, and other macroeconomic factors. This background paper deals with the most recent estimates.

OTA'S analysis of CBO's estimate of the Health Security Act is based mainly on a CBO report, *An Analysis of the Administration's Health Proposal,* released in February 1994 (38) and a related revenue estimate released by the Joint Committee on Taxation, *Summary and Estimated Revenue Effects of Tax Provisions of the Administration's Health Security Act (43).*

OTA's analysis of Lewin-VHI's estimate is based on a Lewin-VHI report, *The Financial Impact of the Health Security Act,* released in December 1993 (13).

Compared with analyses of other major legislation, federal analysts have released relatively more information about the methodology used to estimate the effects of health reform (7). However, most of the information federal and private analysts have released so far provides only a general description of their methodology. With a few rare exceptions, analysts typically do not publish information on the specific input parameters and algorithms (i.e., basic analytic steps) that they used.

Without such information, it is extremely difficult to account for the differences in analysts' estimates. In most instances, OTA can only infer the major factors that may have contributed to the differences based on its understanding of the general methodology.

ESTIMATES OF FEDERAL OUTLAYS

I Expenditures for Subsidies/Discounts

To ease the burden of insurance costs on individuals and expand insurance coverage, the Health Security Act would provide subsidies for premiums and cost-sharing to early retirees, low-income families, and employers. Employer subsidies would be determined by firms' h-ms' health insurance costs, payroll, and size. Specifically, the Health Security Act would place limits on insurance payments by employers in regional alliances on a sliding scale from 3.5 to 7.9 percent of the payroll, depending on the size and average wage of the firm.

Differences in Analysts' Estimates

Analysts' estimates of federal subsidies represent the single largest budgetary item in the estimated additional Federal expenditures under the Health Security Act (from 40 to 60 percent, depending on different analysts' estimates). The estimates also account for the greatest variation across analysts' estimates of federal budget effects. In absolute monetary terms, the largest difference in analysts' estimates is the employer subsidies, with the difference between CBO and the Clinton Administration amounting to approximately $86 billion for the six-year period 1995 to 2000. Table 2-1

3 In this background paper, OTA does not distinguish between documents with the same estimates and will refer to them as the Clinton Administration's December 1993 estimates.

4 The Clinton Administration attributes the differences in two estimates to the fact that its most recent projections are based on the economic assumptions in the 1995 budget proposal, while the earlier projections are based on the economic assumptions in the 1993 midsession review (51).

Table 2-1: Estimates of Federal Expenditures for Premium Subsidies, 1995 to 2000 ($ billions)

Premium subsidy estimates	Clinton Administration	Congressional Budget Office	Lewin-VHI	CBO vs. Clinton Administration $ (%)	Lewin-VHI vs. Clinton Administration $ (%)	Lewin-VHI vs. CBO $ (%)
Family subsidy	$1930	$217	$195,5	$24 (12,4 %)	$25 (1 3%)	-$21.5 (-99%)
Employer subsidy	931	179	1429	859 (92 3)	49.8 (53 5)	-361 (-20.2)
"Cushion"	412	NA	NA	NA	NA	NA
Total gross subsidy	3274	396	3384	686 (21)	11 (34)	-576 (-14 5)

KEY . NA = not applicable

SOURCE Office of Technology Assessment, 1994, based on data from Lewin-VHI, Inc., The Financial Impact of the *Health Security Act* (Fairfax VA. Dec. 9, 1993), U S Congress, Congressional Budget Office, *An Analysis of the Administration's Health Proposal* (Washington, DC February 1994), U S Executive Office of the President, Off Ice of Management and Budget, *Budget of the U.S. Government,* FY95 (Washington, DC U S Government Priting Office, February 1994)

provides a detailed comparison of analysts' estimates for the various types of subsidies.

The estimates of federal premium and out-of-pocket subsidies essentially are determined by three critical factors:

- the estimated premium levels in the first year of reform for health plans in regional alliances,
- assumptions about the growth rate of premiums, and
- the baseline estimates of eligible families and firms, assumptions about future eligibility, and assumptions about the behavioral responses to the subsidies.

The Estimated Premium Level

The relationship between the regional alliance premium and the estimates of federal premium subsidies is intuitive. Higher premium levels will lead to an increase in premium subsidies for both employers and families, other things being equal. Because of the uncertainty of determining, a priori, the premiums for the "standard benefit package" and thus the cost of the subsidy program, the Health Security Act capped the amount of total federal payments for premium subsidies to the regional alliances (section 9102).[5] The act also specifies the method for estimating the average premium level for the "standard benefit package" under the regional alliances (section 6002) and establishes limits on the growth rate of regional alliance average premiums.

The general methodology used to estimate the premiums takes into account the baseline spending for the covered benefits, the inducement effects among the previously uninsured and underinsured individuals, and the number of persons with different family structures covered by regional alliances.

The premiums CBO estimated were on average 15 percent higher than those of the Clinton Administration and about the same as those estimated by Lewin-VHI. Table 2-2 shows a comparison of the average premium levels under the regional alliances estimated by the three analytical groups. Differences in the methods and data used account for the differences in premium estimates.

[5] In many instances, the Clinton Administration's reform proposal has placed a cap on federal spending for specific programs (e.g., long-term care grants to states and premium subsidy payments to regional alliances). Other analysts mayor may not accept the capped amount in the legislation as a "reasonable" estimate for the specific federal spending, The spending caps specified in the legislation are based on what the Clinton Administration has projected the spending levels would be to achieve its policy objectives. Other analysts might contest whether the projections are based on "appropriate" data and/or methodologies. In the case of the premium subsidy, for example, CBO'S estimates suggest that it believes the Clinton Administration has underestimated the premium costs under the reform as well as the size of the population eligible for the premium subsidies.

TABLE 2-2: Estimates of Average Annual Regional Alliance Premiums Per Worker[a]

	Clinton Administration 1994 dollars	CBO 1994 dollars	Lewin-VHI 1998 dollars
Single person	$1,933	**$2,100**	$2,732
Married couple	3,865	4,200	5,464
One-adult family	3,894	4,095	5,172
Two-adult family	4,361	5,565	5,975

[a]The Clinton Administration and CBO's estimates are for average premiums in 1994, whereas Lewm-VHI's premiums reflect the average regional alliance premiums in 1998, taking into account the effect of premium cap prescribed in the-Health Security Act

SOURCE. Office of Technology Assessment, 1994, based on data from A.M. Rivlin, D .M. Cutler, and L .M. Nichols, "Financing, Estimation, and Economic Effects, " *Health Affairs 13(1) 30-49, 1994,* Lewin-VHI,, Inc , The *Financia/ Impact of the Hea/th Security Act* (Fairfax, VA. Dec. 9, 1993), U.S. Congress, Congressional Budget Off Ice, An Analysis *of the Administrations Hea/th Proposa/* (Washington, DC. February 1994)

The Clinton Administration's premium estimates are based on the March 1992 Current Population Survey (CPS) and the expenditure and utilization data reported in the 1987 National Medical Expenditure Survey (NMES).[6] Since the sum of health care expenditures reported in the NMES is less than the comparable totals reflected in the National Health Accounts (NHA), the expenditure data are adjusted to be in line with the 1994 NHA. To estimate expenditures under reform, analysts at the Health Care Financing Administration (HCFA) further adjust the predicted utilization and expenditure figures to account for the changes in health insurance coverage and out-of-pocket costs for health care among the uninsured and underinsured population that would occur under the Health Security Act. Finally, to account for the fact that uncompensated care is expected to disappear with universal coverage, **the** estimated premiums are adjusted downward to reflect the effect of reduced cost-shifting (18).

CBO provided only brief discussion in its report on how it derived its estimates of the premiums under the Health Security Act. No information on the data sources for the estimates was presented in their report. However, CBO analysts indicated to OTA that the premium estimates were based on the March 1993 CPS (which provided demographic and income data) and the 1987 NMES (which provided information on the use of health care services) (9).

According to CBO, the premium estimates were derived from baseline spending on private health insurance premiums and all other health care spending for individuals who could be covered by regional alliances under the Health Security Act. The baseline spending was then adjusted for two factors. First, CBO increased the baseline spending in proportion to the anticipated changes in utilization by currently uninsured people. Second, CBO increased the base amount by another 5 percent to reflect its assumption that the standard benefit package would be 5 percent more expensive than the current average benefit package for insured people. In comparing its own premium estimates with those of the Clinton Administration, CBO suggested that the Clinton Administration's calculation did not include certain public spending such as state and local subsidies to public hospitals for the uninsured people. Also, the Clinton Administration estimate was not adjusted to reflect private health insurance data.

Lewin-VHI derived its premium estimates using the expenditure data reported in the 1987

6 Both the HCFA and the Agency for Health Care Policy and Research (AHCPR) within the Clinton Administration have developed their own estimates of the premiums under the reform. The Clinton Administration used the HCFA premiums in all of its estimates of the subsidies as well as the federal budgetary and national health expenditure effects of the reform, therefore the discussion here will foeus only on HCFA'S analysis.

NMES and then adjusted the NMES data on household health care spending to reflect the comparable totals in the NHA. The NMES health care spending data were further adjusted to reflect higher premium payments and cost-sharing requirements reported in the 1991 Health Insurance Association of America (HIAA) employer survey. Based upon a review of documentation provided by the Clinton Administration, Lewin-VHI suggested that five factors account for the fact that its premium estimates are 15 to 17 percent higher than the Clinton Administration's:

- the fact that Lewin-VHI accounted for aging of the baby boom population (i.e., a faster growth of the elderly population that tends to use more health services), while the Clinton Administration did not,
- Lewin-VHI's assumption that HMO premiums would be higher than the fee-for-service premiums because HMOs require little patient cost-sharing,
- Lewin-VHI lower adjustment for uncompensated care,'
= the fact that Lewin-VHI estimated higher unit costs for care to newly insured persons, and
- the fact that Lewin-VHI made additional adjustments of the NHA (which was used as a benchmark for current spending) with private-sector data sources *(22).*

The Growth Rate of Premiums

In addition to the differences in premium estimates in the first year of reform, another issue is the growth rate for premiums. If the growth in premiums is much higher than projected, the federal subsidies will increase substantially. The Health Security Act would cap on the growth rate of premiums for the standard benefit package under the regional alliances such that it would not exceed the population growth and inflation factors specified in the legislation.

The Clinton Administration's subsidy estimates were based on the assumption that under reform premiums would grow only at the rates specified in the Health Security Act. CBO also assumed that the growth rate of premiums under the regional alliances would not exceed the legislated level. In other words, the premium limit set forth in the Health Security Act would be 100 percent "effective." Although CBO discussed the uncertainty of the impacts of the limits on the quality of care and access to care it did not elaborate on why it assumed the premium limit would be 100 percent effective.[8]

As detailed in a separate OTA report (45), Lewin-VHI assumed the premium cap would be about 85 percent "effective" (21). According to Lewin-VHI, the aging of the baby boom generation and the higher failure rate of health plans in the regional alliances would force the premiums to grow above the proposed target rates.

Analysts' assumptions about the effectiveness of the premium limit were based large] y on a judgment of how the various cost control mechanisms are designed and whether they will support the limit specified in the legislation. As discussed in the previous OTA report *Understanding the Estimates of National Health Expenditures Under Health Reform,* there is evidence that some government cost-control mechanisms have reduced the growth of certain type of expenditures (45). Analysts may have taken this evidence into con-

[7] Currently, private sector premiums reflect some of the costs to providers of uncompensated care due to cost-shifting. Presumably, with universal coverage these costs would no longer exist. In their calculation, Lewin-VHI assumed that only hospital uncompensated care would disappear under reform while the Clinton Administration assumed that both hospital and physician uncompensated care would disappear.

[8] CBO's rationale for the l(X) -percent effectiveness rating may be based on the fact that the Health Security Act not only specified the process for setting the initial premiums and the premium targets in subsequent years, it also went further to define the "penalties" for breaching the premium targets.

sideration. However, there is currently no direct empirical evidence to validate the effectiveness of premium limits per se in containing the growth of health care costs, or, more specifically, the increases in health alliance expenditures.

Eligibility and Behavioral Responses to Subsidies

Estimates of total federal subsidies also hinge on assumptions about the behavioral responses to the subsidies, which in turn affects the estimates of the numbers of families and firms eligible for subsidies. These issues place a great demand on the data system, especially in the case of estimates of employer subsidies.[9] There is, however, no consensus among analysts on the appropriate sources for firm-level data for the estimation of employer subsidies.

To estimate the employer subsidies, the Clinton Administration used the CPS and imputed an average wage per worker (50). In contrast, CBO obtained the firm-level payroll information from the Census Bureau's 1990 County Business Patterns data, adjusted for the growth in employment and wages over time (38). CBO suggested that the Clinton Administration's method of imputation understates the variation in average wages among firms and led to an underestimate of the baseline number of workers in the firms eligible for subsidies (38). Lewin-VHI has suggested that CBO'S method overestimates the costs of the subsidies by underestimating the number of low-wage workers who are in single family households (and therefore would receive lower subsidies).

CBO assumed that the subsidy provisions would create incentives to cluster, or sort, low-wage workers into firms with lower average payroll to minimize premium payments and maximize federal subsidies.[10] Although empirical research is lacking, CBO assumed that such sorting would affect 20 percent of the workers potentially eligible for the subsidies within the 10-year period after reform. CBO did not present any additional rationale for this particular assumption.

The Clinton Administration, in its estimates of the cost of the subsidies, did not directly model the effect of behavioral responses to the subsidies. Rather, its estimates rely upon a separate allowance, or "cushion," equal to 15 percent of the estimated total subsidy. The Clinton Administration suggested that this 15-percent contingency would cover potential behavioral responses to the subsidies. There is, however, no explanation in the Clinton Administration's document why it chose this particular figure. In a personal correspondence with OTA analysts, a Clinton Administration official indicated that the 15 percent figure was derived from two factors. First, an assumption that under health reform there could be changes in employment patterns such as greater "outsourcing." Second, the potential impacts on subsidy costs were estimated with an alternative assumption of 2 percent unemployment under health reform (6).[11]

Lewin-VHI's document did not clearly indicate whether it incorporated behavioral responses in its estimates of the employer subsidy.

1 Expenditures for New Benefit Programs

The Health Security Act would establish two major new benefits: prescription drug reimbursement under Medicare Part-B and federal grants to the states to provide community-based long-term care for individuals with severe disabilities. The degree of variation across analysts' estimates of the cost of new benefits depends, in part, on the

---

9 Because the Health Security Act capped employers' premium spending on the basis of average payroll and firm size, information on the distribution of average payroll across different firm size is a crucial element in *the* estimates of employer subsidies.

10 This is because the Health Security Act capped the employers' premium payments (to the regional alliances) on a sliding scale from 7.9 to 3.5 percent of the payroll. As the size and average payroll of the firm decreased, the levels of federal premium subsidies would increase.

11 The Administration correspondence, however, did not identify the magnitude of the outsourcing effect that the Clinton Administration had assumed to formulate the level of "cushion." Additionally, the 2 percent unemployment effect does not reflector capture the (specific) behavioral responses pertinent to the premium subsidies,

way the programs are designed and the payment mechanisms specified in the legislation.

Differences in Analysts' Estimates: Medicare Drug Benefit

Analysts' estimates of the Medicare Part-B prescription drug benefit represent less than one-fifth of the estimated new federal expenditures proposed under reform. In absolute monetary terms, the largest difference in analysts' estimates is less than $14 billion for the six years from 1995 through 2000. In relative terms, as shown in table 2-3, the Clinton Administration's estimated costs of the Medicare drug benefit program are much higher than Lewin-VHI's, and slightly lower than CBO'S.

The estimates of federal outlays for the Medicare Part-B prescription drug benefit are determined by three factors:

- the baseline expenditures for prescription drugs by the potential beneficiaries,
- the assumption about the demand elasticity for prescription drugs (i.e., the inducement effect due to insurance coverage), and
- the number of eligible beneficiaries and the participation rate of the eligible population.

The estimates of the Medicare drug benefit illustrate how even when analysts' estimates are close, they may still be subject to some uncertaint y. The Clinton Administration, for example, used a lower baseline expenditure for prescription drugs but a much larger demand inducement effect than CBO. Although both inputs differ from CBO'S inputs, they tend to offset each other and thus CBO and the Clinton Administration arrived at similar estimates. Using the Clinton Administration's lower baseline expenditures and CBO'S lower demand inducement effect would result in a lower projection of the federal expenditures than the Clinton Administration has estimated. Similarly, using CBO'S higher baseline expenditures and the Clinton Administration's higher demand inducement effect would result in a projection of expenditures even higher than the $73 bill ion estimated by CBO.

Baseline Expenditures for Prescription Drugs

Analysts' estimates of baseline spending for prescription drugs by Medicare beneficiaries are based on data reported in the 1987 NMES. The figures are adjusted for the increases in prices and/or utilization between 1987 and the base year of

TABLE 2-3: Estimates of Federal Expenditures for New Benefit Programs, 1995-2000 ($ billions)

Benefit provisions	Clinton Administration	Congressional Budget Off ice	Lewin-VHl	CBO vs. Clinton Administration s *(“/0)*	Lewin-VHl vs. Clinton Administration *$ (“/0)*	Lewin-VHl vs. CBO *$ (%)*
Medicare prescription drug benefit	$691	$73	$593	$39 (56 %)	-$98 (-14 2%)	-$137 (-18 8%)
Community-based long-term care benefit program	567	61	64.7	4.3 (7.6)	80 (14 1)	37 (6 1)
Total	1258	134	124,0	82 (66)	-18 (-1 ,4)	-lo (-7 5)

SOURCE Off Ice of Technology Assessment, 1994, based on data from Lewm-VHl, Inc , The Financial Impact *of the Health Security Act* (Fairfax, VA. Dec 9, 1993), U S Congress, Congressional Budget Office, *An Ana/ysls of the Administrations Health Proposal* (Washington, DC February 1994), U S Executive Office of the President, Off Ice of Management and Budget *Budget of the U S Government,* 1795 (Washington, DC U S Government Printing Office, February 1994)

the projection.[12] Since all analysts have obtained the **data** on prescription drug spending from the same data source, their estimates of baseline expenditures presumably would not differ significantly. CBO, however, reported that its estimated baseline expenditures are higher than those of the Clinton Administration (38). CBO'S higher baseline prescription drug expenditures may result from its adjustment for underreporting that it believed existed in the 1987 NMES data. Neither the Clinton Administration nor Lewin-VHI reported making any sort of adjustment for underreporting of prescription drug expenditures.

Demand Elasticity for Prescription Drugs

Not all Medicare Part-B beneficiaries have private supplementary insurance that covers prescription drugs. Thus, analysts have to account for the additional demand for prescription drugs that insurance would induce among those previously without prescription drug coverage. Analysts differed, however, in how they accounted for this inducement effect.

The Clinton Administration assumed that each dollar of new Medicare prescription drug coverage would induce an additional 60 cents of prescription drug spending (50).

CBO based its estimate on its earlier study of the Medicare catastrophic drug insurance program (28), which suggested that different "inducement effects" must be considered for three separate groups of Medicare enrollees: 13

- ~ Those who already have prescription drug coverage, either through Medicaid or private supplementary insurance, would not increase their utilization of prescription drugs.
- Those with supplementary insurance to cover the copayment and deductible for physician services but no drug coverage would increase their use by 7 percent.
- 8 Those without any supplementary insurance would increase their use by 60 percent.

Clearly, the Clinton Administration has assumed a much higher inducement factor than CBO for Medicare beneficiaries who currently have supplementary insurance to cover the copayment and deductible for physician services but no coverage for prescription drugs (60 versus *7* percent). There are no differences between the Clinton Administration and CBO in their assumptions about the inducement effects for the other two groups.

Lewin-VHI used a somewhat different approach to estimate the additional demand and spending for prescription drugs by Medicare beneficiaries currently without drug coverage. Lewin-VHI used information on prescription drug utilization by Medicare beneficiaries who had private prescription drug coverage before the reform as a reference to adjust for the prescription drug utilization of those previously without prescription drug coverage.[14] The different approach adopted by Lewin-VHI may account for the difference between Lewin-VHI's estimate and those of CBO and the Clinton Administration (nearly$14 billion and $10 billion). However, Lewin-VHI did not report the inducement effect implied by their analysis so the source of the difference is difficult to isolate.

Participation Rate Among Potential Beneficiaries

The Clinton Administration assumed that 500,000 high-income Medicare beneficiaries would disenroll from Medicare Part-B because of the proposed increase in premiums, while all of the re-

---

12 Analysts have used different years as their base year for projection. Both the Clinton Administration and CBO used 1994 as their base year. Lewin-VHI adjusted its 1987 expenditures to 1992 figures.

13 The 1989 CBO study based its conclusions on the Rand Health Insurance Experiment. See CBO (28) for details.

14 Lewin-VHI based its estimates on the Health Benefits Simulation Model (HBSM) it had developed. Depending on whether any actual service utilization occurred, the adjustment of utilization can either be based on a *her-decking* technique or on a *duplicating* approach. For a detailed description of the Health Benefits Simulation Model, see Lewin-VHI (13).

maining beneficiaries would be covered by the new prescription drug benefit. Neither CBO nor Lewin-VHI considered the possible disenrollment effect, but rather assumed that all Medicare Part-B beneficiaries would remain in Medicare Part-B and accept and participate in the drug benefit program.

Differences in Analysts' Estimates: Long-Term Care Benefit

As in the case of estimates for the Medicare drug benefit, analysts' estimates of the proposed community-based long-term care program represent less than one-fifth of the estimated additional federal expenditures under the Health Security Act. As shown in table 2-3, in absolute terms, the largest difference among analysts' estimates is $8 billion for the period from 1995 through 2000.

There is, however, one major difference between the Medicare prescription drug benefit and the new long-term care program for severely disabled individuals. The former is essentially part of an entitlement program, while the latter is designed as a federal grant program to states. The total amount of federal appropriation and the phase-in schedule for the long-term care program are specified in the Health Security Act. For the fiscal years from 1995 through 2000, the states would receive $4.5 billion, $7.8 billion, $11.0 billion, $14.7 billion, and $18.7 billion, for a six-year capped total of $56.7 billion. 's The Clinton Administration used these figures as its estimates of the federal outlays for the long-term care program.

Since total federal spending for the program would be capped, one might assume that the estimates of federal expenditures would be the same. CBO, however, stated that federal spending for the long-term care program would be higher than the amount prescribed in the legislation. According to CBO, states would spend about one-fourth of their savings from the elimination of their long-term care expenditures under Medicaid on other optional Medicaid services not mandated by the federal government. As a result, the government would have to spend more matching funds on the Medicaid program. Whether states would actually respond as CBO assumed is not certain.

Lewin-VHI stated that its figures for the long-term care program expenditures were the amounts budgeted in the legislation. Nevertheless, Lewin-VHI'S numbers differ from those in the legislation by $8 billion. One explanation for the discrepancy is that Lewin-VHI's figures include other outlays, such as tax incentives for long-term care and other provisions that liberalize the Medicaid personal needs allowance. Another explanation is that the figures represent Lewin-VHI's own estimates of federal expenditures for the program instead of the budgeted amounts stated in the legislation as suggested in the Lewin-VHI document.

Potential Variations in Estimates of the Long-Term Care Program

Although the long-term care program is not an entitlement program for individuals under the Health Security Act, the Clinton Administration has based its capped budget amount on the assumption that

[15] This capped budget amount does not include the effect of state transfers of Medicaid enrollees to the new program, which was estimated separately to have a $13 billion to $14 billion offset effect. The capped budget amount also does not include the additional federal outlays from tax incentives for long-term care and other provisions that liberalize the Medicaid personal needs allowance, which the Clinton Administration projected at approximately $5.5 billion from 1995 through 2000(5 I).

the program would provide benefits to all participating eligible individuals.[16] The expenditures were derived from the estimated participation rates and average annual costs across population groups with different underlying disabil- ities. However, all the input parameters in the Clinton Administration's estimates, especially the size of the severely disabled population, are likely to be subject to uncertainty.[17] If analysts used different assumptions for any of the input parameters, they would arrive at different estimates of the expenditures for the long-term care program.

The three estimates reviewed here suggest that analysts do not perceive the long-term care benefit as an entitlement program. Because the long-term care benefit is a capped federal-to-state grant program, assumptions about eligibility, utilization, and costs per unit of service are not relevant toestimate federal spending. However, if the size of the eligible population is understated while federal funding is capped, services for part of the eligible population would have to be denied, or the states would have to decide whether to provide the benefits out of their own funds. Hence, the initial estimates of the size of the eligible population could become extremely important for federal and state policy makers.

I Savings from Existing Public Programs (Medicare and Medicaid)

To provide funding for the new benefit programs, the Health Security Act would increase Medicare Part-B premiums, establish a new Medicare Hospital Insurance (HI) tax for state and local government employees, reduce Medicare payments to hospitals and physicians through numerous changes in the current reimbursement formulas, and increase Medicare patient cost-sharing for certain services.[18]

Medicaid would be substantially restructured under the Health Security Act. Current Medicaid noncash recipients would be excluded from Medicaid coverage and incorporated into the regional alliance health plans (with income-based premium subsidies from the federal government). The individual mandate provision would require individuals who are no longer eligible for Medicaid coverage and not covered by employment-based insurance to purchase private health insurance. Most other beneficiaries would maintain their Medicaid coverage under a capitated payment system in the regional alliance health plans. The growth of Medicaid costs would be limited to the growth of insurance costs in the private sector

16 The Clinton Administration estimated that there are 3.1 million severely disabled individuals who would be eligible for the long-term care benefit, with the elderly accounting for about 73 percent of the eligible population, the mentally disabled 9 percent, and others about 18 percent (50).

17 Many factors, including the validity of the survey data used to identify and project the population with Severe disability, and the Stringency and enforcement of eligibility criteria, would affect the baseline estimates of how many individuals among different population groups would be eligible for the benefit. OTA is currently conducting a separate study on the eligibility criteria of the federally-mandated long-term care program.

18 Major changes in Medicare payments to providers prescribed in the Health Security Act include: reducing capital payments to hospitals; lowering indirect medical education adjustment payments to hospitals; reducing in the hospital market basket index update factor; and limiting the growth of physician payments to the growth rate of gross domestic product. In addition, payments for disproportionate share hospitals, which are additional payments to hospitals that serve a disproportionate share of low-income beneficiaries, under Medicare (and Medicaid) will be eliminated due to universal coverage. The Health Security Act would also impose a 20-percent and 10-percent patient cost-sharing for laboratory and home health services, respectively.

TABLE 2-4: Estimates of Federal Savings from Medicare and Medicaid, 1995-2000 ($ billions)

Medicare and Medicaid savings	Ciinton Administration	Congressional Budget Office	Lewin-VHI	CBO vs. Clinton Administration $ (%0)	Lewin-VHI vs. Clinton Administration S (%)	Lewin-VHI vs. CBO $ (%)
Reduced payments to providers (Medicare)	$88 4a	$81	$79.9	-$74 (-84%)	-$85 (-9.6%)	-$1.1 (-1 4%)
Additional Part-B premium/Hl tax (Medicare)	17 6[a]	15	14,9	-26 (-15)	-2.7 (-15)	-01 (-o 1)
Imposing patient cost-sharing (Medicare)	162	15	270	-12 (-74)	108 (66 7)	12 (80)
Others (Medicare)	22a	3	2.1	08 (364)	-01 (-4 5)	-09 (-30)
Total Medicare savings	1183	1 12b	1239	-63 (-53)	56 (4 7)	$11.9 (106)
Total Medicaid savings	608	54	667	-68 (-11 2)	59 (9 7)	$127 (235)

[a] The Clinton Administration's February 1994 document did not provide information on these separate sources of savings For Illustrative purposes, the three iftgures shown here are drawn from the Administration's December 1993 estimates Figures from the February 1994 estimates, if available, would be lower than what are shown here

[b] Total savings shown are lower than the sum of individual savings sources due to rounding

SOURCE Off Ice of Technology Assessment, 1994, based on data from Lewln-VHl, Inc., The *Fmancial Impact of the Health Security Act* (Fairfax, VA Dec. 9, 1993), U S Congress, Congressional Budget Office, *An Analysis of the Administration's Healfh Proposal* (Washington, DC February 1994), U S Executive Off Ice of the President, Off Ice of Management and Budget, Budget of the *U.S. Government,* FY95 (Washington, DC U S Government Printing Office, February 1994)

because the beneficiaries would be insured through the health plans within the regional alliances. Disproportionate share hospital payments (DSH) would be eliminated.[19] States would be required to return to the federal government savings realized from transferring certain beneficiaries out of Medicaid to the regional alliances.

Differences in Analysts' Estimates

Medicare and Medicaid savings represent a significant portion (about one-half) of the estimated source of funds under reform. As shown in table 2-4, the Clinton Administration, CBO, and Lew in-VHI estimates of savings from both Medicare and Medicaid are reasonably close. CBO'S and the Clinton Administration's estimates of Medicare savings differ by only approximately $6 billion, or 5 percent, while their estimates for Medicaid savings differ by approximately $7 billion, or 11 percent, for the period from 1995 through 2000.

There are, however, some variations in the projected savings from specific sources. Lewin-VHI, for example, projected substantially higher Medicare savings from patient cost-sharing for laboratory or home health services than either the Clinton Administration or CBO. Lewin-VHI's higher estimates of Medicare savings from patient cost-sharing may have resulted from a much larger demand elastic it y for the laboratory and home health services than that assumed by the Clinton Administration and CBO. However, none of the three indicated what demand elasticity they used.

[19] Disproportionate share hospital (DSH) payments are payments provided by Medicare and Medicaid to hospitals that serve a disproportionate share of low-income beneficiaries. The Health Security Act proposes the elimination of payments for DSH based on the assumption that under reform insurance coverage will be universal and hospitals will not be burdened by uncompensated care for the uninsured population. Hence, there will be no need for the special payment factor currently added to the payment formula for the DSH hospitals.

The Clinton Administration projected much higher Medicare savings from reducing payment to providers than CBO and Lewin-VHI. It may be that the Administration assumed higher growth rates for the Medicare baseline expenditures than CBO and Lewin-VHI and thus estimated greater savings from the reduced payments.

ESTIMATES OF FEDERAL REVENUES[20]

| Revenues from New Taxes

The Health Security Act is expected to bring in additional tax revenues from:

- a 75-cent per pack increase in the federal excise tax on cigarettes and an additional excise tax of $12.5 per pound of tobacco content for other tobacco products;
- additional individual and corporate income taxes because of higher individual income and corporate profit resulting from lower health insurance premiums and lower out-of-pocket health care expenses;
- I -percent payroll assessment from corporate alliances; and
- a temporary assessment on employers for early retiree subsidies.

Differences in Analysts' Estimates: Tobacco Taxes

Analysts' estimates of the additional federal revenues from tobacco taxes represent an important funding source under the Clinton Administration's reform proposal (15 to 20 percent, depending on different analysts' estimates). Table 2-5 provides an overview of three different estimates of various new tax revenues under the act. As shown in this table, analysts' estimates of tobacco tax revenues are basically the same. CBO and Lewin-VHI's estimates only differ by 1 to 2 percent from those of the Clinton Administration.

The estimation of tobacco tax revenues is essentially based on three major pieces of information: baseline tobacco consumption, the new product prices resulting from additional taxes, and the reduction in tobacco consumption following higher prices. The major source of uncertainty in this case is how consumers will respond to higher prices.

Lewin-VHI suggested that, based on an estimated -0.4 price elasticity of demand for cigarettes, the additional tax would decrease demand for cigarettes by 18 percent. Although neither the Clinton Administration nor CBO indicated what they assumed about the price elasticity of demand for tobacco products, the agreement of the three estimates suggests that analysts adopted similar assumptions about the magnitude of consumer response.

Even though analysts appeared to agree on their estimates of the revenue effects of a 75-cent excise tax on cigarettes, one should view the estimates with caution. First, a 75-cent per pack or larger tax increase falls outside the range of current U.S. tax rates on tobacco products. Extrapolating consumer behavioral responses (with a constant elasticity assumption) outside the existing tax rate range may underestimate the decline in consumption because the elasticity of demand for cigarettes presumably would fall with higher prices (i.e., a demand elasticity of less than -0.4 may have to be assumed). As a result, analysts' estimates of the

---

20 The estimates of federal revenues within the federal agencies are generally performed by different agencies that generated estimates for expenditures. Within the executive branch, revenue projections are traditionally done by the Treasury Department. Within the legislative branch, revenue projections are performed by the Joint Committee on Taxation (JCT). Since the discussion of health care reform has largely been focused on the expenditure-related issues, substantially less information is available regarding the revenue effects under the Health Security Act. *The* Clinton Administration's primary documentation on the federal budget effects of the act (50), for example, was devoted in its entirety to expenditure-related items. A recent document released by the Treasury's Office of Tax analysis, *Estimating the Impact of Health Reform on Federal Receipts* (49), discusses only the general methodology of revenue projection used by the Department. The document provides no actual projection figures. This OTA report draws the Clinton Administration's revenue projections from the FY 1995 budget proposal (51). CBO's estimates of the revenue effects under the Health Security Act actually come from the JCT analysis, *Summary and Estimated Revenue Effects of Tax Provisions of the Administration's Health Security Act (43). The* JCT analysis, however, provides only limited information about how analysts derived the estimates.

TABLE 2-5: Estimates of New Tax Revenues from Income, Payroll, and Tobacco Products, 1995-2000 ($ billions)

New tax revenues	Clinton Administration	Congressional Budget Office	Lewin-VHI	CBO vs. Clinton Administration $ (“/0)	Lewin-VHI vs. Clinton Administration $ (Y”)	Lewh-VHI vs. CBO $ (%)
Excise tax on tobacco products	$67,4	$68.5	$658	$11 (1 .6%)	-$16 (24%)	-$27 (-39%)
Effects of universal coverage, cost containment, and premium subsidy	284	24	-37	-44 (-1 5.5)	-32.1 (-1 13.0)	-27.7 (-1 154)
Assessment for corporate alliances	242	8	330	-16.2 (66 9)	88 (364)	25,0 (312.5)
Assessment for retiree subsidy	114	13	121	16 (14)	O 7 (6 1)	-09 (-69)

SOURCE Office of Technology Assessment, 1994, based on data from Lewin-VHI, Inc , The *Financial Irnpact of the* Health *Security Act* (Fairfax, VA Dec. 9, 1993), U S Congress, Congressional Budget Office, An *Analysis of the Administration's Health Proposal* (Washington, DC February 1994), US. Executive Office of the President, Office of Management and Budget, Budget of the U.S. Government, FY95 (Washington, DC. U S Government Printing Office, February 1994)

revenues that would be produced by additional tobacco excise taxes may be overstated.

In addition to the effect of higher prices, smoking may also be affected by antismoking regulation. A recent study by Wasserman and colleagues, suggests that smoking behavior responds to regulation (52). As antismoking regulations (e.g., restrictions on smoking in public places) increase, cigarette consumption may decrease further. Furthermore, since smoking is an acquired habit both price and regulation may work not only to reduce the tobacco consumption of current smokers but also to decrease the smoking population in the long run by reducing the number of new smokers .21

Differences in Analysts' Estimates: Taxes on Individual or Corporate Income

Taxable income, from individual wages or corporate profits, is expected to rise if health reform reduces the growth of employer spending on health benefits and insurance premiums (which currently are excluded from employee's taxable income). However, the variation in the estimates of additional tax revenues expected under the Health Security Act illustrate the uncertainties underlying the estimation process. Analysts' projections of tax revenues from income changes differ by more than $32 billion (or, in relative terms, by more than 110 percent) for the period from 1995 through 2000. As shown in table 2-5, both the Clinton Administration and CBO estimate that *a* substantial amount of additional tax revenues would be generated ($28.4 billion and $24 billion, respectively) because of higher taxable incomes resulting from cost containment, lower premium spending, and universal coverage.[22] Lewin-VHI, by contrast, projects no additional tax revenues and that the federal government would in fact experience a $3.7-billion loss in tax revenues.

[21] If the smoking population decrease overtime, tobacco taxes may not be a sustainable source of revenues over an extended period of time. The Congressional Research Service (CRS) recently undertook an economic analysis of cigarette taxes and health care reform. CRS's study suggests that since young smokers are more price sensitive than older smokers, long term cigarette tax revenues will fall to two-thirds of the level of current estimates in all analyses (41).

[22] The actual figure listed in CBO's report *is* $25 billion, which results from rounding the JCT's estimate for each year (38). The $24 billion tax revenue reported here is derived from JCT's more detailed analysis (43).

Estimates of the potential additional tax revenues from higher personal or corporate income can be ascertained by comparing current employer health spending and estimated employer health spending under the Health Security Act.[23] Analysts may differ in their estimates of spending under both the current system and under reform.

The Clinton Administration estimated that, without comprehensive reform, employer spending on health insurance premiums would increase from $180 billion in 1994 to $303 billion in 2000. Under the Health Security Act, employer premium payments would be only $276 billion in 2000, or $27 billion less than under current law. Similarly, CBO calculated that all businesses together would pay $20 billion less for employee health benefits in 2000 under the act (38). It is assumed that all the savings in premium payments would then be subject to either corporate or personal income taxes.

Lewin-VHI estimates that under the current system private employer health spending would increase from $185.0 billion in 1994 to $254.2 billion in 1998 and to $293.2 billion in 2000. Under the Health Security Act, employer spending would be $283 billion in 1998 and $309 billion in 2000. Thus, contrary to what the Clinton Administration and CBO estimated, Lewin-VHI estimated that employers would actually spend $29 billion and $16 billion more on health benefits in 1998 and 2000, respectively. Compared with the other two analyses, Lewin-VHI has assumed lower employer premium spending under the current system and a higher employer spending under the reform.[24] Since it is assumed that employers will offset the higher spending with wage reductions, higher premium costs result in a loss of both income and payroll taxes.[25]

Differences in Analysts' Estimates: Corporate Assessment

Under the Health Security Act, large employers, those with 5,000 or more employees, may elect not to participate in the regional alliances and form their own corporate alliances. These corporate alliances would be subject to a 1-percent payroll assessment because they presumably would benefit from reduced cost-shifting resulting from the universal coverage provision of the Health Security Act. According to the Clinton Administration's estimates, the assessment on corporate alliances represents more than 6 percent of the total expected revenues to be used to fund the reform.

As shown in table 2-5, CBO'S estimate of the revenues from the corporate assessment is nearly 67 percent less than the Clinton Administration's, while Lewin-VHI's estimate is about 36 percent more than the Clinton Administration's. In absolute monetary terms, estimates of additional revenues from the 1-percent payroll tax range from CBO'S $8 billion and the Administration's $24.2 billion to Lewin-VHI's $33.0 billion.

Estimates of revenues from the corporate payroll assessment hinge on analysts' assumptions about the participation rate of corporate alliances. This in turn is determined by each firm's own evaluation of the relative costs of the two options (i.e., regional versus corporate alliances), as well

---

23 Depending on the assumption of how the potential savings would be distributed between employers and employees, the savings can be subject to either corporate or individual income taxes. In the latter case, the estimation of tax revenues would require additional information on the distribution of taxable income across income tax brackets.

24 Lewin-VHI's baseline estimates of employer spending apparently were based on a slower average annual growth rate than that used by the Clinton Administration (approximately, 8.0 percent versus 9.1 percent, according to OTA's calculation). Lewin-VHI also assumed a 17 percent higher initial premium level and a higher premium growth rate than the Clinton Administration.

25 It should be noted that although Lewin-VHI *estimated* that the higher premium costs and employer mandate would result in a $17.9 billion loss of federal tax revenues, they estimated that universal coverage and premium subsidies would have a positive effect on income and are expected to generate $14.2 billion in tax revenues. Taken together, however, Lewin-VHI estimated that the federal government would still face a $3.7 billion loss in tax revenues from changes in premiums under the regional alliances, cost containment, premium subsidies, and universal coverage.

as such factors as corporate philosophy about employee benefits and the fact that a decision to participate in a regional alliance is irreversible. The costs under the regional alliances reflect analysts' estimates of average health plan premiums given reform, while the costs under the corporate alliances reflect analysts' estimates of baseline employer health spending and additional administrative costs. Analysts who assumed relatively high regional alliance premiums and relatively lower baseline employer health spending estimate a relatively larger number of corporate alliances.

The Clinton Administration did not indicate exactly what participation rate it assumed but said that it assumed that "most" of the eligible employers would elect to form their own corporate alliances and thus be subject to the payroll tax.

CBO est i mated that onl y a relative] y small portion of the eligible firms would find corporate alliances financially attractive. According to CBO, a typical firm would have to be able to save at least $800 per employee for health benefits, compared with the standard benefit package in 1996, to consider forming a corporate alliance financially more attractive than joining a regional alliance. Based on data from the March 1993 CPS, CBO estimated that the firms meeting the corporate alliance criterion employ only 23 percent of the employees in eligible large firms, and the percentage would decline further in later years.

Lewin-VHI assumed that all unionized workplaces eligible to choose corporate alliances would do so. while the participation rate among the non-unionized firms would depend on the relative costs of the two options.[26] Overall, Lewin-VHI assumed that 60 percent of the eligible employers would still find corporate alliances a financ ially more attractive option than regional alliances. Given the similarity of their premium estimates, one plausible explanation for why Lewin - VHI and CBO estimated different participation rates in corporate alliances is that Lewin-VHI assumed lower current employer benefit expenses than CBO and thus higher expected savings under the corporate alliances.

Differences in Analysts' Estimates: Retiree Assessment

Under the Health Security Act. early retirees aged 55 to 64 who are not working full time and are eli - gible for Medicare at 65 would receive special subsidies covering their employer share of the premiums. From 1998 through 2000, employers who benefit from the subsidy because they no longer have to pay for these benefits directly are required to "return" to the federal government some of the savings realized. Specifically, the Health Security Act would impose a temporary assessment on employers with base period retiree health costs. The assessment would equal 50. percent of the greater of: 1) the adjusted base period retiree health costs for a given calendar year, 2) the amount by which the employer applicable retiree health costs were reduced due to the enactment of the Health Security Act.

Compared with other sources of funding for reform. the potential revenues from the temporary assessment on early retiree subsidies represent a relatively small portion of federal receipts. As shown in table 2-5, analysts' estimates differ by as much as 14 percent. but the absolute difference is only $1.6 billion for the six-year period from 1995 through 2000.

Since the assessment for retiree subsidies is based on the employers' liabilities for- retiree health benefits before reform. analysts' estimates of potential revenues from the assessment are based on estimates of employers' baseline retiree

[26] Lewin-VHI's document does not indicate why it assumed that all unionized workplaces would opt for corporate alliances. One possible explanation is that unionized workplaces traditionally have preferred to have more direct control over their own benefit programs. Under the regional alliance option, both the employers and employees would have less control over their benefit programs.

health liabilities. Variation in analysts' estimates thus reflect different estimates of the baseline retiree health liabilities currently borne by the employers. None of the analysts provided any detailed information on the subject.

1 Revenues from Recovered Tax Expenditures

In addition to new tax revenues from a higher excise tax on tobacco products, and potential y, from higher incomes and wages, the Health Security Act would attempt to raise additional funds from recovering certain health-related tax expenditures under current law.[27] For example, the act would no longer allow the use of tax-exempt cafeteria plans for employer-sponsored health benefits.[28] In addition, after 2004 the tax exclusion for health insurance premiums would be limited to the costs of the standard benefit package. Because the cafeteria plan provision represents the major source of revenues among all tax expenditure related provisions in the Health Security Act, the discussion here will focus only on the cafeteria plan provision.

Differences in Analysts' Estimates

According to the Clinton Administration, repealing cafeteria plans for health benefits would yield nearly 8 percent of the funds needed to finance reform. As shown in table 2-6, however, analysts' estimates of the amount of tax expenditures that could be recovered differ significantly, both in relative and absolute monetary terms. CBO'S estimate, for example, is $21.4 billion less than that of the Clinton Administration's, a difference of more than 68 percent.

Estimates of recoverable tax expenditures from repealing the cafeteria plan for health benefits depend on:

= the baseline tax expenditures under the plan (and the distribution of such tax expenditures across individuals at different tax brackets), and

TABLE 2-6: Estimates of Recovered Tax Expenditures, 1995-2000 ($ billions)

Clinton Administration	Congressional Budget Office	Lewin-VHI	CBO vs. Clinton Administration $ (%)	Lewin-VHI vs. Clinton Administration $ (%)	Lewin-VHI vs. CBO $ (%)
Recovered tax expenditures (from repealing cafeteria plan for health benefits)					
$31.4	$10	$1 7.0	-$214 (-682 %)	*-$14,4 (-45 9%)*	$7.0 (70 o%)

SOURCE Off Ice of Technology Assessment, 1994, based on data from Lewin-VHI, Inc , The *Fmancla/ Impacf of the Health Security Act* (Fairfax, VA Dec. 9, 1993), U S Congress, Congressional Budget Office, Analysis *of the Administration's Health Proposal* (Washington, DC February 1994), U S Executive Office of the President, Off Ice of Management and Budget, Budget of *the U S Government,* FY95 (Washington, DC U S Government Printing Office, February 1994)

[27] According to CBO, which based its estimates on data from the JCT and the OMB, total federal health-related tax expenditures have grown from $19.7 billion in 1980 to $44.2 billion in 1990, and are expected to grow to $127.8 billion in 2000 under current law (29). However, these expenditures include not only the exemption of employer-paid health insurance premiums, but also various deductions such as medical expenses and charitable contributions as well as untaxed Medicare health insurance benefits.

[28] Under the Health Security Act, the present-law exclusion for employer contributions to health benefits would still be preserved. The rationale for disallowing the use of tax-exempt cafeteria plans (and the flexible spending accounts) for health benefits is to limit employees" ability to shelter their shares of the premiums and out-of-pocket expenses in tax-exempt funds when a tax cap for health benefits is in place.

- assumptions about behavioral responses to changing plans.[29]

Although some published data exist on the magnitude of tax expenditures associated with employer-paid insurance premiums (29,39), no detailed information is available on the tax expenditures associated specifically with health benefits under the cafeteria plans.[30] Neither the Clinton Administration nor CBO has reported its estimate of baseline tax expenditures associated with cafeteria plans nor its assumptions about whether individuals will increase other forms of tax-exempt compensation.

If the Clinton Administration assumed that all current health benefits under cafeteria plans would be replaced with taxable wages, the $31.4 billion of recover-able tax expenditures it projected represents the baseline estimate of this particular tax expenditures. CBO, by contrast, stated only that it assumed that a fraction of the cafeteria plan health benefits would actually end up as wages, Compared with the Clinton Administration's implicit assumption, CBO has assumed that more individuals would opt for other tax-exempt benefits rather than additional wages.

Lewin-VHI estimated baseline health-related tax expenditures under the cafeteria plans to be $34.0 billion from 1995 through 2000, all of which could be recovered if employers did not alter their employee compensation packages. However, Lewin-VHI assumed that employers and employees are likely to shift the compensation into other nontaxable forms of benefits, such as pensions, that could still be included in cafeteria plans under reform. Specifically, Lewin-VHI assumed that only half of the potential revenues it projected ($17.0 billion, from 1995 through 2000) would be realized and the other half would be shifted to other nontaxable compensation.

Lost Revenues from New Tax Expenditures

Under the tax code, self-employed individuals are allowed to deduct only 25 percent of their health insurance costs. Under the Health Security Act, they would be allowed to deduct their health insurance premiums in full.

Estimates of baseline income tax liabilities among self-employed individuals are unlikely to differ significant] y. The number of people who are self-employed, their insurance expenses, and corresponding income tax brackets can be obtained from the Statistics of Income, an income tax database maintained by the Internal Revenue Service, and from such other federal household surveys as the CPS. Additionally, individual behavioral responses to this particular tax code change are unlike] y to be a major factor in analysts' estimates of the potential revenue lost.[31]

As shown in table 2-7, the estimates by the Clinton Administration, CBO, and Lewin-VHI differ at most by only about $1 billion from 1995 through 2000. Because of its relatively small effect on the overall budgetary impacts under health reform, differences in analysts' estimates of this new tax expenditure does not represent an area of particular concern.

---

[29] The behavioral responses in this respect reflect an assumption about the possibility that employers and employees might replace the benefits currently paid for through the cafeteria plans with other tax-exempt benefits rather than with wage compensations. If one assumed that the employee's total compensation remained unchanged, and the employee preferred other tai-exempt benefits rather than wages, there would be substantially less additional wage compensation subject to taxation, and accordingly less tax expenditures would be recovered.

[30] The Department of Labor collects information on the number of employers offering cafeteria plans, the number of employees participating, and the types of options offered through the plans. However, it does not collect information on expenditures under cafeteria plans or how many cafeteria plan participants choose health insurance as part of their cafeteria plan benefits.

[31] It is possible that certain part-time workers may face incentives to become self-employed because of the favorable tax treatment of the insurance expenses of self-employed individuals. However, because only a relatively small number of individuals are involved, this is not likely to be significant in the estimates of new tax expenditures.

TABLE 2-7: Estimates of New Tax Expenditures, 1995-2000 ($ billions)

Clinton Administration	Congressional Budget Office	Lewin-VHI	CBO vs. Clinton Administration $ (%)	Lewin-VHI vs. Clinton Administration $ (%)	Lewin-VHI vs. CBO $ (%)
$8.9	$8	$7 9	-$09 (-1 0.1%)	-$10 (-11 ,2%)	-$0.1 (-1 .3%)

SOURCE Off Ice of Technology Assessment, 1994, based on data from Lewin-VHI, Inc , The *Financial* Impact *of the Health Security Act* (Fairfax, VA Dec 9, 1993), U S Congress, Congressional Budget Off Ice, *An Analysis of the Administration's Health Proposal* (Washington, DC February 1994), U S Executive Off Ice of the President, Office of Management and Budget, *Budget of the U S Government, FY95* (Washington, DC U S Government Printing Office, February 1994)