

Covering America

REAL REMEDIES
FOR THE UNINSURED

Cost and Coverage Analysis of Ten Proposals To Expand Health Insurance Coverage

John Sheils
Randall Haught



The LEWIN GROUP

OCTOBER 2003

Covering America is funded
by a grant from
THE ROBERT WOOD
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ECONOMIC AND
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About the Lewin Group

THE LEWIN GROUP has over 18 years experience in analyzing the impact of major health reform initiatives on major stakeholder groups including employers, providers, governments, and consumers. The Lewin analyses are based upon a model of the U.S. healthcare system called the Health Benefits Simulation Model (HBSM), which first came to prominence in 1989 when it was used to estimate the cost of alternative universal coverage proposals for the Bipartisan Congressional Commission on Health Care. The model was used again by the Advisory Council on Social Security in 1991, and it was used to analyze the impact of President Clinton's health reform proposal in 1993. We have since used to model to simulate numerous health reforms at the state and federal levels ranging from expansions in the Medicaid program to changes in the tax treatment of health benefits.

JOHN SHEILS, a vice president with the Lewin Group, directed this study. Mr. Sheils is a nationally known expert on designing and evaluating health coverage expansion proposals. He joined Lewin in 1980 and has worked to establish the firm as one of the major independent sources of information on the financial impacts of major health reform initiatives. He has testified before

various congressional committees and often works directly with members of Congress in evaluating and developing health reform initiatives. Mr. Sheils also directed an analysis of health reform models proposed by eight major stakeholder groups as part of the Coverage 2000 project sponsored by the Robert Wood Johnson Foundation (RWJF). This included proposals by the American Medical Association, the Health Insurance Association of America, the Service Employees International Union, and the American Hospital Association.

RANDAL HAUGHT is responsible for the development and use of HBSM. Mr. Haught has been the Lewin Group's senior micro-simulation modeler for over 12 years. He developed the models used to simulate the impact of a broad range of health reform proposals including Medicaid expansions, tax credits for employers and individuals, major health insurance market reforms, and the single-payer model. He has also assisted several states in estimating the impact of various expansions in Medicaid and S-CHIP at the state level. Mr. Haught was also the senior micro-simulation modeler for the Lewin Group's analysis of the Coverage 2000 proposals for RWJF.

About Covering America

THE COVERING AMERICA PROJECT promotes serious consideration of a diverse range of comprehensive proposals to provide affordable health coverage for the millions of uninsured Americans. The project has published 17 proposals for major expansion of health coverage written by leading health analysts and researchers. The proposals are available from the Economic and Social Research Institute or on line at www.esresearch.org.

COVERING AMERICA is coordinated by the Economic and Social Research Institute in Washington, D.C., and is made possible by a grant from The Robert Wood Johnson Foundation, Princeton, New Jersey. The Foundation does not endorse the findings of this or any other independent research or policy project.

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Preface

This document is part of the *Covering America* project, which is directed by the Economic and Social Research Institute and supported by a grant from The Robert Wood Johnson Foundation. The purpose of the project is to generate serious thinking and debate about comprehensive policies to extend health coverage to uninsured Americans. One major part of the effort was the publication of a series of major proposals by leading health researchers and analysts that explore a variety of options for moving toward universal coverage. The first volume of 10 proposals was published by the Economic and Social Research Institute in June 2001. In November 2002 a second volume of three additional proposals was published, and in fall 2003, a third volume that includes three more proposals was published. (The books that contain these proposals can be ordered from ESRI, and the proposals are available in PDF on our web site at www.esresearch.org.)

As part of this project, The Robert Wood Johnson Foundation, under the direction of Linda Bilheimer, commissioned John Sheils and Randall Haught of the Lewin Group to prepare estimates of the effects the proposed reforms would have on the number of people who would be covered by public and private health insurance and the costs of extending coverage. This document, which provides estimates for the 10 expansion reform proposals published in volume 1, is the result of that effort.

The Advisory Panel that helped direct the *Covering America* project also played a part in this aspect of the project. Mr. Sheils presented the modeling methodology and preliminary results to the Advisory Panel, and the members provided useful suggestions that led to some additional analysis and refinements

of the results. The reform proposal authors also had an opportunity to review the preliminary results and to comment on the application of the methodology to their specific proposals. Although some changes were made in response to these suggestions, some differences of opinion remain. Because it was thought that debate about these issues could be informative, we permitted authors to append comments to this report, indicating where they may disagree with some aspect of the modeling. These comments appear in the text of the report.

In addition to this summary report, the Lewin Group prepared detailed individual cost and coverage estimates for each of the 10 proposals (referred to as appendices B through K in this report). These are available on the ESRI web site (www.esresearch.org/covering_america.php) and The Robert Wood Johnson web site (www.rwjf.org). Also available is a document that provides a detailed explanation of the methodology used for this study.

The Economic and Social Research Institute extends appreciation to John Sheils and Randall Haught for their willingness to respond to numerous suggestions for revisions by ESRI staff. We also thank Linda Bilheimer of the Foundation for her leadership and cooperation in seeing this effort to its successful conclusion.

Jack Meyer, Ph.D., Director
Elliot K. Wicks, Ph.D., Editor and Manager
Covering America Project
Economic and Social Research Institute

Executive Summary

In 2001, the Economic and Social Research Institute, as part of the *Covering America* project sponsored by The Robert Wood Johnson Foundation (RWJF), published 10 proposals to expand health insurance coverage. Prepared by major experts in the field, these proposals range from expanding eligibility under Medicaid to adopting a tax-financed health care system for the entire non-Medicare population. All of these proposals provide some form of subsidy to lower-income groups. Several are also designed to strengthen consumer incentives to enroll in cost-efficient health plans (Figure ES-1).

The Lewin Group was engaged to develop a detailed analysis of the cost and coverage impacts of these proposals. For each proposal we estimated the reduction in the number of uninsured, the net cost to the federal government, and the financial impact on major stakeholder groups, including providers, employers, consumers, and state and local governments. To facilitate discussion, we classified the 10 proposals into five categories of proposals with similar approaches. These include:

- *Incremental Reforms*: There are two proposals to expand coverage through existing sources, including Medicaid/S-CHIP expansions, and tax credits for private coverage.
- *Voluntary Insurance Pool Proposals*: Three proposals would establish voluntary insurance pools offering a selection of health plans and would provide subsidies for coverage for low- and moderate-income people.
- *Employer Contribution Requirement, that is, "Pay-or-Play," Proposals*: Two proposals would require employers to either provide insurance to their workers or pay a payroll tax that automatically covers their workers under a newly created public plan.
- *Replace the Employer Health Benefits Tax Exclusion with a Tax Credit*: Two proposals would provide refundable tax credits to purchase insurance while making employer contributions for health benefits taxable to the worker.
- *Tax-financed Health Care System*: One proposal

would replace the current premium-financed system with a state-administered payroll tax-financed system covering the entire non-Medicare population.

To illustrate the impact of these proposals, we present cost and coverage estimates assuming that these programs are fully implemented in 2002. For budgetary purposes, 10-year estimates of the cost of these proposals reflecting proposed phased-in dates are presented in the appendices to this report.

Changes in Coverage and National Health Spending

We estimate that there was an average of 41.9 million uninsured people at any given time during 2002. All 10 of the proposals analyzed would substantially reduce the number of people without health insurance. The Wicks et al. and Kronick and Rice proposals are the only ones that require all people to have insurance. However, despite the mandate for universal coverage, we estimate that about 1.6 million undocumented persons and "hard-to-reach" people would remain uninsured (Figure ES-2).

The two "pay-or-play" proposals introduced by Hacker and Weil would achieve near-universal coverage by requiring all employers to provide insurance for their workers. This reduces the number of uninsured by about 37 million people. However, nearly 5 million non-working uninsured people would still be without coverage.

The remaining six proposals would encourage voluntary increases in coverage with premium subsidies, tax credits, and automatic enrollment mechanisms. We estimated the effect of these inducements to obtain coverage based primarily on studies of how changes in the price of insurance and/or the use of automatic enrollment affect the likelihood of obtaining coverage. Our estimates of the reduction in the number of uninsured under these proposals range from about 11.8 million people under the Singer et al. proposal to 26.9 million people under the Butler proposal.

FIGURE ES-1: SUMMARY OF KEY DESIGN FEATURES OF THE “COVERING AMERICA” HEALTH REFORM PROPOSALS

	Medicaid/ S-CHIP Expansion	Personal Income Tax Credit	Premium Subsidy	Employer Tax Credit	Insurance Purchasing Pools	Medicaid Folded into Pools	Subsidized Purchasing Pool	Managed Competition Model	Employer Benefits Tax Exclusion	Coverage Mandate
Incremental Reforms										
Public Coverage Expansion with Employer Tax Credit: Feder, Levitt, O'Brien and Rowland	▲			▲						
Adaptive Tax Credit Plan: Pauly	▲	▲								
Voluntary Insurance Pool Proposals										
An Insurance Exchange Approach: Singer, Garber, and Enthoven		▲			▲			▲	Cap Amount	
Private Public Partnership: Gruber			▲		▲	▲		▲	Cap Amount	
Federal/State Approach: Holahan, Nichols, and Blumberg			▲		▲	▲	▲	▲		
Pay-or-Play Models										
Medicare Plus: Hacker			▲			▲	▲			▲
The Medical Security System: Weil			▲		▲	▲	▲	▲	Cap Amount	▲
Proposals to Replace the Tax Exclusion with Tax Credits										
Tax Credits with Insurance Pool: Wicks, Meyer, and Slow-Carroll		▲			▲	▲			Eliminate Exclusion	▲
Variable Tax Credits: Butler	▲	▲							Eliminate Exclusion	
Tax-Financed Health Care System										
A State-Based Approach: Kronick and Rice					▲	▲		▲		▲

FIGURE ES-2: CHANGES IN PRIMARY SOURCES OF HEALTH INSURANCE UNDER REFORM PROPOSALS

	Coverage Sources (millions)					National Health Spending a/	
	Number Uninsured	Private Coverage Outside Insurance Pools	Private Coverage through New Insurance Pools / Exchanges	New Public Plan	Current Public Programs	Total Health Spending (billions)	Health Spending per Person
CURRENT SYSTEM TOTALS							
Current System (Baseline)	41.9	173.2	N/A	N/A	64.8	\$1,548.0	\$5,550
CHANGES FROM BASELINE							
Incremental Reforms							
Public Coverage Expansion with Employer Tax Credit: Feder, Levitt, O'Brien and Rowland	(12.0)	(7.3)	—	—	19.3	\$26.1	\$93
Adaptive Tax Credit Plan: Pauly	(20.5)	9.5	—	—	11.0	\$36.6	\$131
Voluntary Insurance Pool Proposals							
An Insurance Exchange Approach: Singer, Garber, and Enthoven	(11.8)	(62.9)	74.7	—	—	\$23.0	\$82
Private Public Partnership: Gruber	(14.5)	(117.3)	157.5	—	(25.4)	\$36.7	\$131
Federal/State Approach: Holahan, Nichols, and Blumberg	(15.2)	(85.1)	126.1	—	(25.7)	\$34.0	\$121
Pay-or-Play models							
Medicare Plus: Hacker	(37.0)	(51.0)	—	113.6	(25.6)	\$32.3	\$115
The Medical Security System: Weil	(36.7)	(0.4)	64.5	—	(27.2)	\$57.2	\$204
Proposals to Replace Tax Exclusion with Tax Credits							
Tax Credits with Insurance Pool: Wicks, Meyer, and Silow-Carroll	(40.3)	(50.0)	117.4	—	(27.1)	\$52.1	\$186
Variable Tax Credits: Butler	(26.9)	23.4	—	—	3.5	\$23.5	\$84
Tax-Financed Health Care System							
A State-Based Approach: Kronick and Rice	(40.3)	(173.2)	241.0 ^{b/}	—	(27.5)	\$32.7	\$116

a/ Includes changes in utilization of health services and insurer/program administration, as well as research, construction, and public health activities.

b/ The Kronick and Rice proposal permits states to adopt either a new public plan—such as a single-payer model—or provide private coverage through an insurance pool offering a choice of health plans. For illustrative purposes, we assumed that all states would adopt a private insurance pool model.

Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

All of these proposals would result in an increase in national health spending; increases range from \$23.0 billion to \$57.2 billion for 2002. National health spending in 2002 is estimated to have been about \$1.5 trillion, an average of about

\$5,550 per person. This includes all spending for all health services purchased by all payers, including households, employers, and state, local, and federal governments. It also includes the cost of administering insurance and public pro-

grams. We estimate that health spending for the uninsured will increase by between 40 and 50 percent as this population obtains health insurance, resulting in an increase in total national health spending.

Incremental Reforms

Two proposals would expand coverage through a Medicaid/S-CHIP-style expansion and refundable tax credits. Mark Pauly proposes to cover all people living below 125 percent of the federal poverty level (FPL) under a Medicaid/S-CHIP-style program and to provide a refundable tax credit for private health insurance for people between 125 percent and 325 percent of the FPL. The proposal developed by Judith Feder, Larry Levitt, Ellen O'Brien, and Diane Rowland would also expand eligibility under the Medicaid/S-CHIP program to all people living below 150 percent of the FPL, and allow people with incomes through 300 percent of the FPL to "buy-in" to Medicaid/S-CHIP by paying a premium that varies with income. In addition, the Feder et al. proposal would provide a refundable tax credit to small firms (fewer than 50 workers) with lower-income workers.

We estimate that the Feder et al. proposal would cover about 12.0 million of the 41.9 million people who are without insurance. Federal costs less offsets under this proposal would be about \$34.1 billion, if fully implemented in 2002 (Figure ES-3). The Pauly proposal would reduce the number of uninsured by about 20.5 million people with a net federal cost of \$89.7 billion. Average federal costs per newly insured person would be \$2,842 under Feder et al. and \$4,376 under Pauly. These cost estimates reflect the fact that many of those who would qualify for the tax credits would be individuals and employers who currently have health insurance.

Under both the Feder et al. and the Pauly proposals, we assume that the increase in federal spending would be financed by increases in the personal income tax.

Voluntary Insurance Pool Proposals

Three of the proposals would create voluntary state-operated insurance pools featuring a menu of privately run health plan options that would be open to both individuals and employer groups. These include the proposals developed by John Gruber; Sara Singer, Alan Garber, and Alain Enthoven; and John Holahan, Len Nichols, and Linda Blumberg. Although there are important differences in these proposals, each would provide subsidies to low- and middle-income people to purchase health insurance. To encourage enrollment in plans offered through insurance pools, these subsidies would be available only to people taking coverage through the public insurance pool. These proposals would also create financial incentives for people to enroll in cost-efficient health plans modeled on the principles of managed competition.

Individuals and groups with high health care costs due to age and/or illness would be attracted to the insurance pool because they would generally find the community-rated premium in the pool to be lower than what they now pay for private coverage. Under the Singer et al. and the Gruber proposals, this accumulation of higher-cost people in the pool—known as "adverse selection"—would raise premiums in the pool, which in turn would increase the government's cost of subsidizing premiums for income-eligible people in the pool. Under Holahan et al., the government would pay the full cost of services provided to pool enrollees in excess of the community-rated premium for the entire non-Medicare population in each state. Covering the most costly people in the insurance pool is designed to reduce premiums in the private market, resulting in increased coverage.

We estimate that if fully implemented in 2002, these proposals would reduce the number of uninsured by: 11.8 million people under Singer et al.; 14.5 million people under Gruber; and 15.2 million people under Holahan et al. (Figure ES-2). New federal spending net of offsets to other programs would range from \$102.8

billion under Singer et al. to \$190.5 billion under Gruber. Net federal costs per newly insured person would be about \$8,700 under Singer et al., \$13,200 under the Gruber proposal, and \$8,400 under Holahan et al. (Figure ES-3). These estimates reflect the cost of subsidies to low- and moderate-income people and the government cost of adverse selection in the pools.

The full amount of net new federal spending under the Holahan proposal would be financed with an increase in personal income taxes (\$127.4 billion) (Figure ES-3). The Singer et al. proposal would be financed with a cap on the tax-exempt amount of employer health benefits, raising \$8.4 billion in revenues and increased personal income taxes of about \$94.4 billion. The Gruber proposal would also cap the amount of the employer health benefits tax exemption, resulting in about \$12.0 billion in new revenues, and would raise an additional \$149.1 billion through increases in the personal income tax. In addition, the Gruber proposal includes a state “maintenance of effort” payment based on the amounts states save by folding portions of Medicaid into the insurance pools created under this proposal.

Pay-or-Play Proposals

Jacob Hacker and Alan Weil have each developed proposals that require employers to contribute to the cost of covering their workers. Under both proposals, employers who do not provide a minimum standard of coverage for their workers are required to pay a payroll tax that automatically covers their workforce under a newly created public program. Non-workers are also required to have insurance and can obtain coverage through the public plan. Under both plans, people who are not covered through these means are automatically enrolled in the public plan. The Hacker proposal would cover public plan enrollees under a single public health plan modeled on Medicare, while the Weil proposal would provide a selection of private health plans to enrollees with financial incentives for people to enroll in lower-cost plans.

The employer payroll tax would be 7.7 per-

cent under Weil, compared with 5.0 percent under Hacker.¹ Firms with lower-wage workers would generally find that paying the payroll tax is less costly than offering coverage, while firms with higher-wage workers generally would find it less costly to provide the coverage. Thus, the Hacker proposal would be more costly to the government than the Weil proposal because the former would attract more workers to the public plan while collecting lower revenues per enrollee. We estimate that the net new federal cost of these proposals (including offsets) would be \$241.9 billion under the Hacker proposal and \$160.9 billion under the Weil proposal (Figure ES-3).

We estimate that both proposals would cover about 37.0 million of the 41.9 million people who do not have insurance. Due to the employer requirements under these proposals, we assume that all workers and dependents would be covered. Under both proposals, non-workers (including workers during periods of non-employment) are also required to have coverage, and a default enrollment process would be created to facilitate coverage. However, these proposals do not include any penalties for failing to have coverage, which is likely to result in less than full enrollment for the non-worker population. Average net federal costs per newly insured person would be \$6,538 under the Hacker proposal and \$4,384 under the Weil proposal.

Both plans would have a significant impact on employer costs. The average cost to firms that do not now offer coverage would average roughly \$1,000 per worker under either proposal. Firms that currently offer insurance would see savings averaging about \$409 per worker

¹ The Weil proposal requires employers who do not provide coverage to pay a total payroll tax of 11.0 percent, 7.7 percent of which is paid by the employer and 3.3 percent is paid by the worker. Under the Hacker proposal, employers who do not provide coverage are required to pay a payroll tax of 5.0 percent, with the worker paying a monthly public plan premium ranging from \$50 for single individuals to \$140 for couples with children.

FIGURE ES-3: NET NEW FEDERAL SPENDING BY SOURCES OF REVENUES FOR HEALTH REFORM PROPOSALS

	Net New Federal Spending a/	Amount Financed by Capping or Eliminating Tax Exclusion	Amount Financed by Payroll Taxes	Amount Financed by Income Taxes	State Maintenance of Effort	Net New Federal Cost per Newly Insured Person
Incremental Reforms						
Public Coverage Expansion with Employer Tax Credit: Feder, Levitt, O'Brien, and Rowland	\$34.1	—	—	\$34.1	—	\$2,842
Adaptive Tax Credit Plan: Pauly	\$89.7	—	—	\$89.7	—	\$4,376
Voluntary Insurance Pool Proposals						
An Insurance Exchange Approach: Singer, Garber, and Enthoven	\$102.8	\$8.4	—	\$94.4	—	\$8,712
Private Public Partnership: Gruber	\$190.5	\$12.0	—	\$149.1	\$29.4	\$13,229
Federal/State Approach: Holahan, Nichols, and Blumberg	\$127.4	—	—	\$127.4	—	\$8,382
Pay-or-Play Models						
Medicare Plus: Hacker	\$241.9	\$1.7	\$126.0	\$87.5	\$26.7	\$6,538
The Medical Security System: Weil	\$160.9	—	\$64.7	\$58.9	\$37.3	\$4,384
Proposals to Replace Tax Exclusion with Tax Credits						
Tax Credits with Insurance Pool: Wicks, Meyer, and Silow-Carroll	\$230.8	\$76.4	—	\$154.4	—	\$5,727
Variable Tax Credits: Butler	\$236.1	\$131.0	—	\$105.1	—	\$8,777
Tax Financed Health Care System						
A State-Based Approach: Kronick and Rice	\$551.7	—	\$505.1	\$46.6	—	\$13,689

a/ Includes total federal expenditures for programs and program expansions under these proposals (including tax credits) less: savings from replacing and/or reducing current subsidy programs; offsets to other programs (including federal employee health benefits), and changes in federal payroll and income taxes resulting from the program's impact on wage levels.

Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

under Hacker and about \$22 per worker under Weil (see Figure 17 below).

Public costs under these programs would be partially funded with the payroll taxes paid by employers that decide not to provide health insurance, along with state maintenance-of-effort payments based on the amounts saved by folding much of Medicaid into the new programs. These proposals would also require increases in federal income tax collections of \$87.5 billion under Hacker and \$58.9 billion under Weil (Figure ES-3).

Replacing the Tax Exclusion with Tax Credits

Two of the proposals analyzed in this study would replace the existing income tax exclusion for employer-sponsored health benefits with a refundable tax credit (“refundable” means that the amount of the tax credit is permitted to exceed the amount of taxes due). These include the proposals developed by Stuart Butler and by Elliot Wicks, Jack Meyer, and Sharon Silow-Carroll. Under these proposals, all individuals and families would receive the full amount of the credit regardless of how much of the premium was paid by an employer. The tax credit also would be available to people without employer-sponsored health benefits, who, under the current system, receive no tax benefits. However, all employer contributions for health benefits would be treated as taxable income to the employee.

These proposals are intended to change consumer incentives in ways that would help control health spending. Under the current system, employer contributions for health care are tax-exempt. The value of the exemption increases indefinitely as the employer’s contribution rises. This encourages the use of comprehensive health plans with minimal copayment requirements that can lead to increased utilization of health services and higher costs. The tax credit model is designed to reduce this incentive by permitting people to enroll in lower-cost plans without forfeiting any of their tax benefit.

Both of these proposals emphasize market-

based consumer choice as a means of controlling costs. The Wicks et al. proposal would facilitate this market-based approach by establishing “aggregate purchasing arrangements” (APAs) throughout the country that offer a selection of health plans to small groups and individuals, while the Butler proposal adopts insurance market rules that assure access to coverage in the private market at premiums that do not vary with health status. Also, while neither proposal requires employers to contribute to the cost of covering their workers, both require employers to facilitate coverage for their employees, including administering health plan selection and arranging for premium payments and tax credits through payroll withholding.

There are several important differences between the two proposals, however. First, the Wicks et al. proposal requires all Americans to have health insurance while the Butler proposal does not. Second, the minimum benefits package under Butler is a high-deductible policy, while Wicks et al. require a more comprehensive benefits package. Third, unlike the Wicks et al. proposal, the tax credit under the Butler proposal applies to both premium payments and out-of-pocket expenses, which is expected to encourage individuals to enroll in high-deductible health plans. Fourth, the Wicks et al. proposal eliminates the tax exemption for employer health benefits from the personal income tax, but retains it for the Social Security FICA payroll tax. The Butler proposal eliminates the exclusion for FICA taxes as well. Consequently, the Butler proposal creates stronger financial incentives for consumers to shift to cost-efficient health plans.

We estimate that the Wicks et al. proposal would achieve nearly universal coverage. Of 41.9 million people who do not now have coverage, about 40.3 million would become covered. This estimate reflects the fact that the Wicks et al. proposal includes substantial tax penalties for people who do not maintain their coverage. The 1.6 million people who remain uninsured would be undocumented immigrants and some low-income people who do not file tax returns. The

Butler proposal would cover about 26.9 million of those who are now without coverage. If implemented in 2002, net new federal costs less offsets would be about \$230.8 billion under Wicks et al. and \$236.1 billion under Butler (Figure ES-3). Federal costs per newly insured person would be about \$5,727 under the Wicks et al. proposal and \$8,777 under the Butler proposal.

Both proposals would eliminate the tax exemption for employer-sponsored insurance for the federal income tax, raising about \$76.4 billion. The Butler proposal would raise an additional \$54.6 billion by eliminating the exclusion in determining Social Security payroll taxes, and eliminating section 125 cafeteria plans for health benefits. Personal income taxes would also be increased to fully fund these programs by \$154.4 billion under the Wicks et al. proposal and \$105.1 billion under the Butler proposal.

Tax-Financed System

Richard Kronick and Thomas Rice propose that state governments individually devise programs for financing a minimum level of coverage for all of their legal residents. States could establish a single-payer program or create an insurance pool that offers a selection of health plans. The federal government would support the states with financing raised from a payroll tax assessed on all employers and employees (9.4 percent). In turn, the federal government would mandate that states create such programs within minimum specifications, including:

- States would be required to establish a program covering at least 98 percent of their population. The benefits package must include low cost sharing such as a \$10 copayment for all physician and hospital outpatient services and a \$10 copayment of each prescription. There would be no deductible.
- At least one zero-premium health plan must be offered in all areas of the state.
- All health plans in the state's program, including those with zero premiums, must include a comprehensive benefits package (no require-

ment for long-term care).

We estimate that virtually all Americans would be insured under the program. Those who remain uninsured—about 1.6 million people—would be undocumented immigrants and lower-income non-workers who are difficult to reach. If fully implemented in 2002, the various state programs would cover about 240.9 million people with net new federal spending of \$551.7 billion (Figure ES-3). This would be funded with payroll tax revenues of \$505.1 billion and an increase in federal personal income taxes of \$46.6 billion.

The proposal would increase health spending in currently insuring firms by about \$197 per worker. The cost of the proposal to firms that do not now offer coverage would be about \$1,760 per worker.

Caveats

Many of the proposals considered in this study have never been attempted on a broad scale in the United States. Consequently there are few data on the likely outcomes of such programs that can be used to estimate their impacts. In particular, programs that substantially restructure the health care financing system could fundamentally change consumer, employer, and provider incentives in ways that would have a significant impact on program costs.

To illustrate the potential sensitivity of our estimates to these assumptions, we estimated the number of uninsured who would become covered and the net federal costs under each of these reform proposals using alternative participation and cost assumptions. We developed high-range and low-range estimates of enrollment by varying the participation rates for these programs by about 25 percent above and below our best estimate values. We also estimated net program costs under these proposals at these high- and low-range enrollment levels assuming that per capita costs and revenues differ from our projections by 5 percent above and below our best estimates. This provided us with the range estimates pre-

sented in Figure 21 in the report.

Although we have tried to base our analyses on the best data and research now available, these estimates should be considered illustrative of potential program impacts rather than point estimates of actual program outcomes. In fact, our analysis indicates that the ultimate impact of these proposals on government health spending

and coverage is very sensitive to assumptions about employer and consumer behavioral responses under the new incentives created by these programs. Consequently, policy makers should recognize that, over time, any major health initiative is likely to require continued refinements in program design and financing. ■

Introduction

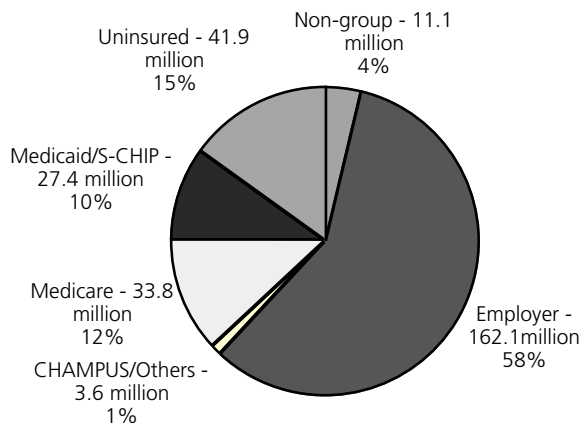
In 2001, the Economic and Social Research Institute, as part of the *Covering America* project sponsored by The Robert Wood Johnson Foundation (RWJF), published 10 proposals to expand health insurance coverage. Prepared by major experts in the field, these proposals range from expanding eligibility under Medicaid to replacing the current tax exclusion for employer-sponsored health benefits with refundable tax credits. They all involve providing subsidies to assist lower-income people in obtaining coverage. Several proposals are also designed to change the incentives faced by those who now have health insurance coverage to encourage consumers to enroll in cost-efficient health plans.

The Lewin Group was engaged to develop a detailed analysis of the cost and coverage impacts of these proposals. For each proposal we developed estimates of the number of people who would become

insured and changes in the number of people with coverage from various sources. As shown in Figure 1, we estimate that there were about 41.9 million uninsured people in 2002 under current policy.

In this project we estimated the cost and coverage impacts of these proposals on major stakeholder groups, including providers, employers, consumers, state and local governments, and the federal government. We developed these estimates using The Lewin Group Health Benefits Simulation Model (HBSM). HBSM is a micro-simulation model of the U.S. health care system designed to simulate the impact of major health reform initiatives on coverage, health services utilization, and health spending by the major payers for care. The model simulates changes in eligibility for public programs such as Medicaid and the State Children's Health Insurance Program (S-CHIP).

FIGURE 1: PEOPLE BY PRIMARY SOURCE OF COVERAGE UNDER CURRENT POLICY IN 2002 (TOTAL POPULATION = 279.9 MILLION)



Note: Coverage presented on an average monthly basis.

Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

It also simulates the impact of changes in the tax treatment of health benefits and other subsidies that affect incentives for consumers, employers, and health plans. In addition, the model includes a simulation of health insurance markets that enables us to estimate patterns of health plan selection by employers and consumers under these health reform models. A detailed documentation of the data and methods used in HBSM is presented in appendix A.

For each of the 10 proposals we prepared a detailed analysis of their cost and coverage effects, including their impacts on major stakeholder groups, which are presented in appendices B through K. These analyses include a brief summary of the provisions and rationale for each proposal. They also present a summary of the assumptions used to simulate the impact of these proposals and a discussion of the results of our analysis.

The purpose of this report is to present the key components of these proposals and to compare their estimated cost and coverage impacts. Due to the complexity of these reform models, we classified the 10 proposals into five categories with similar approaches to reform that will facilitate these comparisons. (Note: In some cases proposals share characteristics with those in more than one group. For purposes of this paper, they were classified according to their most distinguishing features.) These groups of reform models include:

Incremental Reforms: Two proposals expand coverage through existing forms of public and private coverage.

- Judith Feder, Larry Levitt, Ellen O'Brien, and Diane Rowland propose an expansion in Medicaid/S-CHIP, together with a targeted employer health expense tax credit.
- Mark Pauly proposes a Medicaid/S-CHIP expansion, combined with a refundable tax credit for low- and moderate-income individuals and families.

Voluntary Insurance Pool Proposals: Three of the proposals would establish voluntary insurance pools that would offer a selection of private health plans with incentives to enroll in cost-efficient health plans. They also provide subsidies to low- and moderate-income individuals and families.

- Sara Singer, Alan Garber, and Alain Enthoven propose to create insurance "exchanges" offering a

choice of health plans and a refundable health insurance premium tax credit to lower-income individuals and families.

- Jon Gruber proposes a public insurance pool offering a choice of health plans to the Medicaid/S-CHIP population, lower-income people qualifying for premium subsidies under the proposal, and individuals and employer groups that wish to participate.
- John Holahan, Len Nichols, and Linda Blumberg propose to create community-rated insurance pools covering the Medicaid/S-CHIP population, people qualifying for subsidies provided under the proposal, and others who voluntarily choose to be enrolled in the pools.

Pay-or-Play Proposals: Under these proposals, employers must either provide insurance to their workers or pay a payroll tax that automatically covers these individuals under a public program.

- Jacob Hacker proposes a pay-or-play program, called "Medicare Plus," where all individuals who do not have employer coverage are automatically covered under a newly created public program with a modified Medicare insurance package.
- Alan Weil Proposes a "Medical Security System" where people not covered by an employer plan would obtain coverage through a public program sponsoring a selection of health plans with incentives for people to enroll in cost-efficient health plans.

Proposals to Replace the Employer Health Benefits Tax Exclusion with a Tax Credit: Under these two proposals, all individuals and families would receive a refundable tax credit structured in a way that creates financial incentives to enroll in lower-cost health plans. Employer contributions for health benefits would become taxable to the individual.

- Elliot Wicks, Jack Meyer, and Sharon Silow-Carroll propose refundable tax credits for premiums that vary with income for the entire non-Medicare population, while creating insurance pools, called "exchanges," that offer a selection of health plans to all consumers.
- Stuart Butler proposes a refundable tax credit for premiums and out-of-pocket payments for health services that varies with the amount of spending as a percentage of income.

Tax-Financed Health Care System: Richard Kronick

and Thomas Rice propose to replace our current premium-financed system with a payroll tax-financed system. States would be given an allotment of funds to cover their non-Medicare population under either a single-payer system or through a publicly sponsored insurance pool offering a selection of health plans. Financial incentives would be used to encourage enrollment in cost-effective plans.

The estimates presented in the following sections assume that these proposals are fully implemented in 2002. This enables us to compare the impacts of these proposals once they are fully phased in and operational. In fact, it would take several years to implement these programs. Several of these proposals are also phased into operation in a series of steps over a period of several years. In addition, experience shows that there will be a lag of some years between the time these programs are implemented and the point where the population is generally aware of their potential eligibility. Consequently, for budgetary purposes, we provide program cost estimates for

2003 through 2012 that reflect the various phase-in schedules of these proposals in the detailed analyses of these proposals presented in appendices B through K.

In the following sections, we compare the estimated impacts of each of these proposals on the uninsured and major stakeholder groups, including providers, employers, consumers, and governments. We also present range estimates for each of these proposals that illustrate the sensitivity of our cost and coverage estimates to key assumptions.

Our discussion is presented in the following sections:

- Incremental Reform Proposals;
- Voluntary Insurance Pool Proposals;
- Pay-or-Play Proposals;
- Replacing the Tax Exclusion with Tax Credits;
- Tax-Financed System;
- Comparison of Program Impacts; and
- Caveats. ■

Incremental Reform Proposals

Judith Feder, Larry Levitt, Ellen O'Brien, and Diane Rowland propose expanding eligibility for low-income people under the Medicaid and/or S-CHIP programs. They propose that the federal government mandate that states offer full health insurance coverage—either under Medicaid/S-CHIP or a new program—to all individuals living below certain low-income thresholds. They also propose to allow individuals above these income thresholds to “buy in” to these state insurance programs with premiums that vary with income. Additionally, they propose creation of a refundable federal income tax credit for small firms with high percentages of low-income workers that provide health insurance to employees (Figure 2).

Mark Pauly’s proposal would extend coverage to

people living below 325 percent of the federal poverty level (FPL). People below 125 percent of the FPL would be covered under a Medicaid-style program, while people between 125 percent of the FPL and 325 percent of the FPL would qualify for a refundable tax credit of \$1,500 for single coverage and \$3,500 for family coverage. The credit would be phased out for families living between 275 percent and 325 percent of the FPL.

Eligible people would be able to apply the credit to premium payments under either non-group or employer health plans. For workers with employer coverage, the credit would be equal to the credit they qualify for less the value of their tax exclusion for employer health benefits.

FIGURE 2: PROPOSALS THAT EXPAND MEDICAID/S-CHIP AND PROVIDE TAX CREDITS

	Public Program Expansions with Employer Tax Credits: Judith Feder, Larry Levitt, Ellen O'Brien, and Diane Rowland	The Adaptive Credit Plan: Mark Pauly
Public Program Expansions		
Type of expansion	Expansion could be through Medicaid, S-CHIP or a new program	Expansion could be through Medicaid, S-CHIP or a new program
Benefits	Below 150% of FPL — free coverage 150%-200% FPL — contribution required 200%-300% of FPL — buy-in	All below 125% FPL — free coverage
Eligible groups	All including non-custodial adults ^{a/}	All including non-custodial adults ^{a/}
Federal matching rate	Enhanced matching rate (65%-84%, depending on state)	Standard matching rate (50%-74%, depending on state)
Individual Tax Credit		
Income-eligible group	N/A	125%-325% of FPL
Credit amount	N/A	\$1,500 Single-\$3,500 Family
Credit phase-out	N/A	Phase down to \$700 single, \$2,000 family between 275% and 325% FPL
Eligible coverage	N/A	Credit applies to non-group premiums and employer coverage up to the total premium amount. Credit for employer coverage is reduced by value of tax exclusion
Firm Tax Credit		
Eligible firms	Firms with 50 or fewer workers and average payroll less than \$30,000	N/A
Credit amount	Between 6.3% and 50.0% of total premiums depending on firm size and average salary	N/A
Currently insuring employers	Also eligible	N/A

^{a/} Adults who do not have custodial responsibility for a child.

FIGURE 3: PROPOSALS COMBINING MEDICAID/S-CHIP EXPANSION WITH TAX CREDITS IN 2002

	Medicaid Expansion with Employer Tax Credit: Judith Feder, Larry Levitt, Ellen O'Brien, Diane Rowland	The Adaptive Tax Credit Plan: Mark Pauly
Medicaid/S-CHIP Expansion		
Eligible People (millions)	69.5	18.8
Number Enrolled (millions)	19.4	11.1
Net Reduction in Uninsured (millions)	11.3	7.9
Total Cost (billions)	\$43.8	\$32.0
Federal Share of Cost (billions)	\$31.2	\$19.0
State Share of Cost (billions)	\$12.6	\$13.0
Tax Credits		
Eligible People (millions)	13.3	85.7
Number Enrolled (millions)	6.7	80.5
Net Reduction in Uninsured (millions)	0.7	12.6
Total Cost (billions)	\$5.9	\$70.8
Federal Share of Cost (billions)	\$5.9	\$70.8
State Share of Cost (billions)	—	—
Combined Program		
Eligible People (millions)	82.8	104.5
Number Enrolled (millions)	26.1	91.6
Net Reduction in Uninsured (millions)	12.0	20.5
Total Cost (billions)	\$49.7	\$102.8
Federal Share of Costs (billions)	\$37.1	\$89.8
State Share of Costs (billions)	\$12.6	\$13.0
Federal Costs Less Offsets (billions)		
Total Offsets (billions)	\$3.0	\$0.1
Federal Costs Less Offsets (billions)	\$34.1	\$89.7

Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

Under the Pauly proposal, people would be required to report their insurance status to the IRS with their tax returns. Income-eligible people without coverage would be sent coupons for the amount of the credit they are eligible to receive that could be redeemed with insurers for a health insurance policy. To encourage enrollment, people would be permitted to use the coupon to purchase a policy equal in cost to the coupon amount. This would enable people to obtain coverage at no additional cost to themselves. While this would encourage people to take coverage, the insurance they would be able to obtain with the coupon amount is expected to provide only limited benefits (for example, high-deductible plan, etc.).²

We estimate that about 69.5 million people are eligible for the Medicaid expansion and buy-in under the Feder et al. model. We estimate that of these, about 19.4 million would enroll (Figure 3). The number of uninsured people would be reduced by about 11.3 million people, which is about a 27 percent reduction in our estimate of the number of uninsured people in 2002 (41.9 million people). The total cost of this Medicaid/S-CHIP expansion net of partial premium payments under the buy-in would be about \$43.8 billion (including state and federal shares). The federal share of the cost of this program would be \$31.2 billion, with the states paying \$12.6 billion.

² All plans are required to community rate policies that do not require additional payments (that is, premium equals credit amount). However, the premium for cov-

erage in excess of that amount may be risk rated. All policies are guaranteed renewable at premiums no greater than those charged for average risks.

About 13.3 million workers and dependents are in small low-wage firms that would be eligible for the employer tax credit under the Feder et al. proposal (that is, firms with 50 or fewer workers with average salary below \$30,000). Of these, about 6.7 million people would be covered by firms that would receive the credit. This includes about 6.0 million people in qualifying firms that already offer coverage and about 700,000 people in firms that are induced to offer coverage by the tax credit. The cost of the employer tax credit would be \$5.9 billion.

The Medicaid-style coverage expansion under the Pauly model would cover people living below 125 percent of the FPL. About 11.1 million of these people would enroll, of whom 7.9 million would

be people who otherwise would have been uninsured. Total federal costs net of offsets would be about \$19.0 billion. About 85.7 million people would be eligible for the tax credit under the Pauly proposal, of whom 80.5 million would enroll. The credit would reduce the number of uninsured by another 12.6 million people at a total federal cost of \$70.8 billion (that is, net of offsets).

The total reduction in the number of uninsured under the Pauly proposal (that is, Medicaid expansion and credit combined) would be 20.5 million people at a net federal cost of \$89.7 billion. The Feder et al. proposal would reduce the number of uninsured by a total of about 12.0 million people. Total federal costs net of offsets under the Feder et al. proposal would be about \$34.1 billion in 2002. ■

Voluntary Insurance Pool Proposals

Three proposals would create voluntary open-access, state-operated insurance pools featuring a menu of privately run health plan options at various premium levels. These include the proposals developed by John Gruber; Sara Singer, Alan Garber, and Alain Enthoven; and John Holahan, Len Nichols, and Linda Blumberg.

Participation would be open to both individuals and employer groups. Although there are important differences among these proposals, each would provide subsidies to low- and middle-income people to purchase health insurance. To encourage enrollment in health plans offered through insurance pools, these subsidies would be available only to people taking coverage through the pools. All three of these proposals would create incentives to enroll in cost-effective plans by requiring individuals to pay the cost of enrolling in more costly health plans.

The subsidies under the Singer et al. proposal would be in the form of refundable tax credits, while the Gruber and Holahan et al. proposals would provide premium subsidies (Figure 4). Also, the Gruber and Holahan et al. proposals would fold the non-Medicare Medicaid/S-CHIP population into the premium subsidy program, while Singer et al. would leave the Medicaid/S-CHIP program unchanged.

Under all three proposals, premium subsidies are available to both workers with employer coverage and people who do not work for an employer that offers coverage. However, the basis for computation of subsidies varies across proposals. Under Singer et al., workers with employer coverage can take the maximum of the tax credit or the employer health benefits tax exclusion. In the Gruber proposal, the premium subsidy is first applied to the employee contribution amount, with the remaining subsidy used to reduce the employer contribution. Under Holahan et al., the subsidy applies only to the worker premium contribution amount.

Under all three proposals, the premium subsidy is available to workers only if they take coverage

through the insurance pools.³ For example, under Holahan et al., all employers that sponsor insurance are required to offer coverage through the public plan as an option so that employees are able to obtain the subsidies available only through the pool. However, employers are encouraged under Holahan et al. to offer private coverage alternatives as well. This differs from the Gruber proposal, which makes subsidies to employees available only if the employer offers coverage exclusively through the pool.

Premiums in the plans offered through the pools are based on actual health spending for people enrolling in these pools under both the Gruber and Singer et al. proposals.⁴ However, the Holahan et al. proposal would set premiums based on average costs for the non-Medicare population throughout the community. By charging a community rate, the pool is designed to attract people with expected costs that are in excess of the community rate, while permitting people with lower expected costs to obtain coverage in the private market at premiums that are lower than the community rate.

This migration of higher-cost cases to the public pool under the Holahan et al. proposal is designed to reduce private insurer premiums for those who remain in the private market, resulting in an increase in the number of employers offering coverage. The program effectively subsidizes the cost of coverage for higher-cost populations by an amount equal to the difference between actual costs for the enrolled population and the state-wide community rate. The increase in coverage resulting from this approach and the cost of subsidizing care for higher-cost populations are reflected in our estimates.

³ Under the Singer et al. plan, workers not enrolled in the public exchange (that is, public insurance pool) can receive the subsidy if their employer has established itself as an exchange by meeting certain coverage requirements.

⁴ Under the Singer et al. plan, the premium is community rated across all enrollees in all exchanges, including those established by employers.

FIGURE 4: VOLUNTARY INSURANCE POOL PROPOSALS

	Insurance Exchange Approach: Sara Singer, Alan Garber, Alain Enthoven	Public/Private Partnership: Jon Gruber	Federal/State Approach: John Holahan, Len Nichols, Linda Blumberg
Purchasing pools	Voluntary “exchanges” for employers and individuals: offers selection of health plans	Voluntary for employers and individuals: offers selection of health plans	Voluntary for employers and individuals: offers selection of health plans
Employer coverage	Employers can continue private plans, offer coverage through an exchange, or establish a selection of plans so they qualify as an exchange	Employers can offer private coverage, through the public pool, or both	Employers must offer coverage through the public pool, but may also offer other private insurance as well
Availability of subsidies	Only to those in an exchange	Only to those in firms where the employer offers only public pool coverage	Only to those in public pools
Subsidies for workers with employer coverage	Take the maximum of the credit or the tax exemption	Subsidy applies to full amount of the premium	Subsidy applies to worker share of premium only
Form of subsidy	Refundable tax-credit	Premium subsidies	Premium subsidies
Amount of subsidy	Tax-credit equals 70% of median cost plan for those with incomes below \$31,000 single/\$51,000 family; subsidy phased-out between \$31,000 and \$41,000 for single/\$51,000 and \$61,000 for families	Subsidy equals full premium for median-cost plan for people below 150% FPL; phased out between 150% FPL and 300% of FPL	Subsidy equals full premium for people below 150% of FPL; phased out between 150% of FPL and 250% of FPL
Disposition of Medicaid/S-CHIP	Retained in current form	Folded into public pool	Folded into public pool
Federal match for subsidies	100%	100% with state maintenance-of-effort payment	Enhanced matching rates, 65%-84%, depending on state
Default enrollment	Default enrollment of people eligible for full credit; unclaimed credit amount transferred to state to provide services to uninsured	Automatic enrollment of people below 150% of FPL	No provision
Managed competition incentives	—People pay full cost of enrolling in higher cost plan in exchange —Tax exclusion for employer benefits capped at 105% of median cost plan (phased-in over 10 years)	—In the public pool, all people must pay full cost of enrolling in above median-cost plan —Tax exclusion for health benefits capped at median cost plan	Employers are required to make a fixed premium contribution; people pay full cost of enrolling in higher-cost plan
Basic premiums in public plan	Actual costs in exchange	Actual costs in public plan	Community-wide costs; designed to attract high-cost cases to public pool and reduce cost of private coverage outside the pool

All three of these proposals would change the sources of coverage for a large portion of the population. For example, under the Gruber model, about 157.5 million people would be enrolled in the public pool (Figure 5). Enrollment in private health plans under his proposal would decline from 173.2 million people under current policy to about 55.9 million people. Public pool enrollment would reach 126.1 million people under the Holahan et al. proposal, with about 88.1 million people covered under private health plans.

Enrollment in exchanges under Singer et al.

would be 74.7 million people, with 110.3 million people covered under private health plans that are not constituted as exchanges under this proposal. The number of uninsured would be reduced from its current level of 41.9 million people by 11.8 million people under Singer et al.; 14.5 million people under Gruber; and 15.2 million under Holahan et al..

Premium subsidies under the Gruber proposal would be about \$247.6 billion. The federal share of this cost would be \$190.5 billion after offsets. Net federal costs would be about \$102.8 billion under Singer et al. and \$127.4 billion under Holahan et al.

FIGURE 5: COST AND COVERAGE IMPACTS OF VOLUNTARY INSURANCE POOL PROPOSALS IN 2002

	Insurance “Exchange” Approach: Sara Singer, Alan Garber, and Alain Enthoven	Public/Private Partnership: Jon Gruber	Federal/State Approach: John Holahan, Len Nichols, and Linda Blumberg
Sources of Coverage (millions)			
Reduction in Uninsured (currently 41.9 million people)	11.8	14.5	15.2
People with Private Coverage through Insurance Pools/Exchanges	74.7	157.5	126.1
People with Private Coverage outside Insurance Pools/Exchanges (currently 173.2 million people)	110.3	55.9	88.1
Program Costs (billions)			
Total Subsidies ^{a/}	\$109.3	\$247.6	\$156.0
Federal Spending Net of Offsets	\$102.8	\$190.5	\$127.4

a/ Includes the cost of premium and cost sharing subsidies including the cost of administering these subsidies. For the Holahan et al. proposal, subsidies include the cost of coverage in the voluntary pool in excess of community rated premium collections.

Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

COMMENTARY BY SARA SINGER, ALAN GARBER, AND ALAIN ENTHOVEN

We believe that our proposed plan will be substantially less costly than estimated by the Lewin Group. First, with strong incentives for participation, the exchanges created in our proposal would enjoy economies of scale. FEHBP has administrative costs of about 1 percent. Lewin assumes that administrative costs are nearly five times as large, based on the experience of a single, very small exchange.

Second, under our proposal health plans compete on price, since people pay the differences in premiums out of pocket. Lewin’s analysis, which assumes that the benefit packages will be at best similar to current managed care plans, assumes no savings from a choice of plans including more cost-effective packages of services. In addition, managed competition, by injecting price sensitivity in the entire marketplace, is likely to lower costs for all plans—in part, by well-documented managed care spillover effects.

The simulation also greatly underestimates the effective coverage under our plan by ignoring the direct care provision that will occur through default plans. In the absence of a compulsory plan, some individuals will inevitably fail to purchase insurance. Under our proposal, such individuals, if they are low income, would automatically be enrolled in a default plan, where they would have coverage and access to primary care and preventive services. The default plans are discussed but apparently not included in Lewin’s coverage estimate.

Our plan contains several features to minimize the effects of adverse selection, including risk adjustment within and across insurance exchanges. If employers with below-average-risk workers whose incomes are high enough to make it advantageous to forgo the tax credits seek coverage in the non-exchange market, our proposal provides for inclusion of the non-exchange market in the risk-adjustment calculations.

Finally, the “bottom-line” measure of cost per incremental covered life and the suggestion that a lower cost represents “efficiency” is misleadingly narrow. Any plan with tax credits for low-income Americans achieves benefits by providing income support for all the poor and by extending health insurance coverage. Only the latter benefit is included in a performance measure like the cost per incremental insured life. Only if one believes that income transfers to the poor are wasteful or irrelevant can this benefit be ignored.

COMMENTARY BY JOHN HOLAHAN, LEN NICHOLS, AND LINDA BLUMBERG

Our goals in developing this plan were to help both low-income Americans and those with high expected health care costs buy health insurance. We also wanted to create a safe haven to purchase insurance, preserve a major financial role for employers, avoid mandates, permit choice among plans, and provide a decision-making role for states. These features are keys to political viability.

We applaud the Lewin Group (Lewin) for its comprehensive modeling efforts, but our own estimates suggest that our plan would provide more coverage at a lower cost than they predict. We offer only two of many technical comments in this limited space.

First, Lewin asserts that participation rates among the uninsured are 70 percent for those for whom coverage is free. But the data in Table 16, Appendix F, indicates that actual participation rates are well below this. Lewin assumes no participation in the pool among the uninsured who are currently eligible for Medicaid but not enrolled. This assumption is unrealistic since the new pool, with half the insured population, would carry less stigma and fewer enrollment barriers than today's Medicaid. Therefore, participation and coverage rates should be significantly higher than Lewin's analysis allows.

Second, program costs should be lower. The authors model fully phased-in coverage immediately, while cost savings are discussed only in the long run and only in the appendix. Lewin acknowledges in the appendix but not in the main estimate that the bargaining power of the new pools would be strong, given their market share, and that costs would therefore grow substantially more slowly than under current law. These cost savings are not part of the estimates shown in the main report.

We agree that many Americans—about 20 million—would remain uninsured. This is true for any voluntary plan. However, our plan provides a stable, easily administered foundation that would allow people with low income and high risk to purchase quality health insurance. We believe the combination of these two types of subsidies is critical for the ultimate success of reforms intended to expand coverage. Once these structures are functioning effectively, mandates or higher subsidy rates can be used if and when Americans decide that universal coverage is a high priority.

Pay-or-Play Proposals

Jacob Hacker and Alan Weil have each created proposals that require employers to contribute to the cost of covering their workers. Under both proposals, employers who do not provide a minimum standard of coverage for their workers are required to pay a payroll tax that automatically covers their workers under a newly created public program. Non-workers are also required to have insurance and can obtain coverage through the public program. In addition, both programs eliminate the current Medicaid/S-CHIP programs for the non-Medicare population and cover these individuals through the public program, unless they become covered by an employer health plan. Under both proposals, people who are not covered through these means are automatically enrolled in the public program.

The “Medicare Plus” program proposed by Hacker would cover all people without employer coverage under a single publicly operated health plan modeled on Medicare (Figure 6). Benefits would be based on the current Medicare benefits package, modified to include prescription drugs, maternity services, and pediatric care. The benefits package also would be changed to include a \$250 deductible with an out-of-pocket limit of \$2,500 that applies to all services.⁵

Unlike the Hacker proposal, the public program under the “Medical Security System” proposed by Weil would be an insurance pool offering a selection of private health plans to participants. The pool would offer at least one zero-premium health plan. Participants would be permitted to enroll in more costly plans but would be required to pay the full amount of the additional premium for more costly coverage. Under the Weil proposal, the benefits package provided by plans in the insurance pool would be determined by a national board.

Under both proposals, employers must either provide a minimum standard benefits package

(that is, the benefits package offered in the public program) or pay a payroll tax. Employers who decide to offer coverage would be required to pay a minimum percentage of the premium—85 percent for workers and 75 percent for dependents under the Weil proposal. Under the Hacker proposal, employers are required to pay at least 75 percent for employees working 20 or more hours per week and 50 percent for employees working fewer than 20 hours per week.

Payroll tax rates are higher under the Weil proposal than under the Hacker proposal. Under the Weil proposal, the tax paid by employers that do not provide coverage is equal to about 7.7 percent of Social Security-covered earnings (about \$82,000 per year). The tax rate for employers under the Hacker proposal is 5.0 percent of Social Security-covered earnings.

Employers are likely to decide between paying the tax or offering coverage based on whichever costs them less. Firms with lower-wage workers would generally find that paying the payroll tax is less costly than offering coverage, while firms with higher-wage workers generally would find it less costly to provide coverage. Consequently, the percentage of eligible employers choosing to pay the payroll tax increases as the tax rate decreases. Thus, we expect enrollment in the public program to be higher under the Hacker proposal than under the Weil proposal because the Hacker proposal has a lower employer payroll tax rate.

Under both proposals, workers would contribute to the cost of their coverage. Under the Weil proposal, workers in firms that decide to enroll in the publicly sponsored insurance pool (that is, those paying the tax) would pay a payroll tax of 3.3 percent. Under the Hacker proposal, employees in the public plan would pay a monthly premium ranging from \$50 for single individuals to \$140 for workers with a spouse and children. The premium under the Hacker proposal is fully subsidized for people living below 200 percent of the FPL and is phased in for families with incomes between 200 percent and 300 percent of the FPL.

⁵ The current Medicare benefits package does not cover outpatient prescription drugs and does not limit out-of-pocket spending.

FIGURE 6: COMPARISON OF PAY-OR-PLAY MODELS FOR HEALTH REFORM

	The Medical Security System: Alan Weil	Medicare Plus: Jacob Hacker
Employer requirement	Employers that do not provide a minimum standard of coverage must pay a tax that automatically covers their workers and dependents through a public program	
Minimum benefits standard	Minimum standard package determined by national board: —Inpatient/outpatient hospital —Physicians services —Mental health/substance abuse —\$10 co-pay per visit —\$10,000 out-of-pocket limit	Medicare benefits plus: —Prescription drugs —Preventive services —Mental health —Maternity care Revised cost sharing: 20% co-pay \$250 deductible per person \$2,500 per person out-of-pocket limit
Minimum employer premium contribution	85% for workers 75% for dependents	75% for employees working 20 or more hours per week 50% for employees working less than 20 hours per week
Default enrollment	Yes; without financial penalty	Yes; without financial penalty
Payroll tax rates	11.0% total 7.7% employer 3.3% worker	5.0% total 5.0% employer 0.0% worker
Wage base	Social Security covered earnings	Social Security covered earnings
Phase-in of tax rate for currently non-insuring firms	None	1.5% rate reduction phased in over 10 years
Medicaid	Folded into public exchanges	Folded into Medicare Plus
Provider payment levels	Private-sector rates	Medicare rates
Choice of health plans	Selection of plans offered in exchange	None: Medicare Plus only
Premium for workers in public program	None (worker pays employee share of payroll tax)	\$50/month single \$100/month single with children \$90/month married couples \$140/month married couples with children No premium below 200% FPL Phase-in between 200% FPL and 300% FPL
Premium for non-workers in public program	None	No premium below 200% FPL; phase-in between 200% of FPL and 300% of FPL
Employee premium contribution subsidy	—Full subsidy below FPL —Subsidy phased out between FPL and 200% of FPL	—Full subsidy below 200% of FPL —Subsidy phased out between 200% and 300% FPL
Cost sharing subsidy	No cost sharing below FPL	—No cost sharing below FPL —Subsidy phased out between FPL and 150% of FPL
Spousal equity provision	None	Firms with workers covered under a spouse's plan must forward to those plans an amount based upon the payroll tax for those workers. This transfer is administered by the public pool

The Hacker proposal includes a unique feature designed to promote greater equity in the financing of health care for workers across employers. Under today's system, working spouses will often take coverage as a dependent on a working spouse's employer-sponsored health plan. This

means that insuring employers are paying much of the cost of covering workers in other firms. Under either proposal, workers can still elect to take coverage through a working spouse. However, under the Hacker proposal, firms with workers covered on a spouse's plan are required to pay an amount based on the pay-

roll tax; this amount is then forwarded by the public plan to the employers that cover these workers.⁶

Under either of these proposals, the number of uninsured would be reduced by about 37 million people, which is equal to about 88 percent of the 41.9 million people who currently lack coverage (Figure 7). We assume that the pay-or-play model would be fully effective in enrolling all workers and dependents in a health plan. However, monitoring coverage for people is expected to be difficult during periods when they are not associated with employment (that is, as a worker or a dependent). Also, neither proposal specifies any penalties for people who allow their coverage to lapse. Thus, we assume that only about 70 percent of non-workers become covered.⁷ The uninsured would also include many undocumented immigrants who might avoid the government program (we assume full enrollment of undocumented workers while employed). We estimate that about 5.0 million people would remain uninsured despite the use of an automatic enrollment procedure for workers and dependents under both proposals.

Employers would be more likely to elect to pay the tax under the Hacker proposal than under the Weil proposal because the Hacker model imposes a lower payroll tax rate on non-insuring employers. Thus, many of the employers who now sponsor coverage would find it less costly to eliminate their health plan and cover their workers under the public plan. The number of people with private coverage would decline from 173.2 million people under current law to about 121.4 million people under the Hacker proposal. By comparison, private coverage would actually increase to 172.7 million people under the Weil proposal due to the relatively higher employer tax rate under his proposal (7.7 percent).

Public program enrollment would be 64.5 million people under the Weil proposal and 113.2 million people under the Hacker proposal. These enrollees would include the Medicaid and S-CHIP

populations who would become covered under the public program; workers and dependents in firms that decide to pay the tax rather than provide coverage; and other non-workers who decide to enroll in the public program.

FIGURE 7: ESTIMATED IMPACT OF THE PAY-OR-PLAY MODELS FOR HEALTH REFORM IN 2002

	The Medical Security System (MSS): Alan Weil	Medicare Plus: Jacob Hacker
Changes in Sources of Coverage (in millions)		
Reduction in Uninsured (41.9 million people under current policy)	36.9	37.0
People in Public Program	64.5	113.2
People with Private coverage (173.2 million under current policy)	172.7	121.4
Program Costs (in billions)		
Federal Cost Net of Offsets	\$160.9	\$241.9
Federal Cost Net of Payroll Tax and State Maintenance of Effort (assumed to be raised through income tax)	\$58.9	\$87.5
Employer Costs per Worker		
Currently Insuring Firms	(\$22)	(\$409)
Currently Non-insuring Firms	\$970	\$1,124

Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM)

The total federal cost of these programs if fully implemented in 2002 would be \$160.9 billion under the Weil proposal and \$241.9 billion under the Hacker proposal. After subtracting payroll tax revenues, state maintenance-of-effort payments (\$37.3 billion under Weil and \$26.7 under Hacker) and other offsets, net federal costs drop to \$58.9 billion under the Weil proposal and \$87.5 billion under the Hacker proposal. These include total benefits costs under the public program and other subsidies less payroll tax revenues, premium payments to the public program, and state maintenance-of-effort payments.

The impact of these proposals on employers' costs would vary depending on whether the firm is already offering insurance, the level of benefits provided, and the wage level of their workers. While most insuring firms already comply with the minimum benefit and contribution requirements under these proposals, some insuring firms would face additional costs for upgrading their health plans to meet the minimum benefits

⁶ However, the specific calculations used vary by whether the workers involved are covered under the public plan or private coverage.

⁷ We assumed that about 70 percent of non-workers would enroll in the public plan based on the average enrollment rate in the Medicaid program for uninsured people.

and employer contribution requirements. Insuring employers would also incur the cost of covering workers who are currently ineligible under their health plans (that is, part-time and temporary workers).

However, some insuring firms would be able to reduce their costs by discontinuing their plans and paying the payroll tax. Also, under the spousal equity provisions in the Hacker proposal, employers that offer insurance would receive payments from other employers (administered by the public plan) for each working dependent spouse who is covered as a dependent under their plan. Thus, some insuring firms could see substantial savings under

these proposals.

The average cost per worker in non-insuring firms would be about \$970 under the Weil proposal and \$1,142 under the Hacker proposal. This includes the employer payroll tax in firms that decide to pay the tax as well as the cost of insurance among firms that decide to provide coverage. On average, costs per worker would change little under the Weil proposal, although some individual firms would see substantial changes in costs. However, under the Hacker proposal, employers that currently offer insurance would, on average, save about \$409 per worker. This reflects the impact of the spousal equity provisions of the Hacker plan. ■

COMMENTARY BY ALAN WEIL

I developed the Medical Security System to illustrate an alternative vision of the American health care system in which everyone has health insurance and everyone contributes to the cost of that coverage. A key feature of the Medical Security System is its reliance upon the political process to establish the value of the core coverage guaranteed to everyone, which then determines the tax rate necessary to generate the funds for that coverage. Layered on top of that political process is the individual's ability to purchase more or better coverage with his or her own funds. In essence, the Medical Security System leaves to the political process how much of the overall cost of the health care system will be shared and how much will be borne by individuals and families.

The cost estimates generated by the Lewin Group do not purport to take these dynamics into consideration. This is appropriate, given the limitations of their model. However, the consequence is that the estimates implicitly assume that this fundamental change in how the health care system is financed has no effect on health care spending.

The estimates provide some useful information for comparing the short-term consequences of changing the health care system in various ways. They do not capture the effects of changes in the underlying dynamics of the system, which is the most interesting dimension along which the proposals vary.

I have two specific comments on the estimates. First, the tax rates in the proposal were selected as an illustration of what would be needed to generate in aggregate what employers and employees pay for health insurance coverage today. I neglected to include a transition period or subsidies for lower-wage firms. The results of the modeling highlight the importance of these features. It is also likely the political process would yield lower tax rates (and less comprehensive coverage) than I used for illustration.

Second, the estimates assume that every employer decides whether to offer coverage or pay the tax solely on the basis of minimizing cost. This assumption is not consistent with employers' current behavior, which also takes into consideration labor market conditions and the employers' own expectations about their ability to manage cost. I believe firms that promote better health care delivery would be disproportionately likely to offer coverage, thereby providing a source of innovation in the health care system.

COMMENTARY BY JACOB HACKER

The Lewin Group's work deserves commendation, and I largely agree with the findings. Nonetheless, the presentation invites erroneous judgments, and so I briefly outline here what the results do and do not mean.

Let me begin, however, by stressing the most important finding: My plan would cover nearly everyone while adding only \$32.3 billion, or \$115 per American, to the amount the nation spends for health care. Despite my appreciation of this central result, I must note that the estimated coverage expansion is clearly too small, because it does not account for the provision of my plan that automatically covers all income tax filers who do not show proof of insurance. On the other hand, the estimated administrative costs (3.5 percent to 11 percent, depending on the size of an enrollee's employer) are clearly too high: Medicare pays only around 3 percent for administration, and Medicare Plus's costs should not be much more.

My main objection, however, is to the prominent use of "net new federal cost per newly insured person" to compare plans. First, the measure does not really capture "net new federal cost"—that is, federal spending minus offsetting spending and revenue changes. Rather, it essentially represents new federal spending, which is properly seen as "gross new federal cost." Second, the measure has the perverse effect of encouraging proposals to shift costs onto private actors and the states. (By way of illustration, a chief reason Weil's otherwise similar plan scores "better" is that its much higher payroll tax discourages employers from enrolling their workers in the public program, thereby imposing more of the costs of mandated coverage on business.)

Finally, and most important, the measure penalizes proposals that cover a larger share of Americans, because the marginal cost of covering the uninsured rises as more are covered. Thus, the measure is misleading not simply because reform proposals "are designed to achieve more than just reducing the number of uninsured." More fundamentally, it misleads because it is only weakly related to the true challenge of financing a proposal and because, all else equal, federal spending per newly insured person is necessarily higher for proposals that cover more Americans.

Replacing the Tax Exclusion with Tax Credits

Two of the proposals analyzed in this study would replace the existing income tax exclusion for employer-sponsored health benefits with a refundable tax credit. These include the proposals developed by Stuart Butler and by Elliot Wicks, Jack Meyer and Sharon Silow-Carroll.

Under these proposals, all individuals and families would receive the full amount of the credit, regardless of how much of the premium was paid by an employer (Figure 8). The tax credit also would be available to people without employer-sponsored health benefits who under the current system receive no tax benefit for health insurance. However, all employer contributions for health benefits would be treated as taxable income to the employee.

These proposals are intended to change consumer incentives in ways that would help control health spending. Under the current system, employer contributions for health care are tax-exempt. The value of the exemption increases indefinitely as the employer's contribution rises, which encourages the use of comprehensive health plans with minimal cost-sharing requirements that lead to increased health spending. For example, under the Wicks et al. tax credit model, individuals receive a fixed amount (for example, \$700 single/\$1,500 family) that can be applied to the purchase of insurance. Selecting a lower-cost health plan does not reduce the amount of the tax subsidy (unless the policy costs less than the credit) as it would under the current tax exemption. This encourages individuals to conserve on health spending by seeking out cost-effective health plans.

The Butler plan alters incentives differently. Under the current system, the tax exclusion applies only to insurance premiums and not to out-of-pocket spending for health services (except in certain section 125 plans), which creates a financial incentive for people to consume as much of their health care as possible through insurance. This encourages use of comprehensive health plans that tend to increase health services utilization by making people largely insensitive to cost at the

point of service. Under the Butler proposal the credit applies to both premium payments and out-of-pocket spending for health services, which eliminates the tax incentive to obtain health services through insurance. The expectation is that this would encourage enrollment in less comprehensive plans making people more sensitive to the price of services with a resulting reduction in health spending.

Both of these proposals emphasize market-based consumer choice as a means of controlling costs. While under today's system employee coverage options are limited to the plans selected by their employer, consumers would be able to take their tax credit and use it to buy coverage from any health plan they chose. The Wicks et al. proposal would facilitate this market-based approach by establishing "aggregate purchasing arrangements" (APAs) throughout the country that offer a selection of health plans to small groups and individuals. Both Butler and Wicks et al. would also adopt insurance market rules that assure access to coverage at premiums that cannot vary with the health status of the individual.

The authors of both proposals specify a minimum benefits package. In the Wicks et al. proposal, all individuals in the non-Medicare population are required to have insurance coverage that is at least as comprehensive as the current Medicare benefits package plus prescription drugs and well-child care. The minimum benefits package under the Butler proposal would cover most medical services and prescription drugs subject to 20 percent coinsurance, a \$1,000 deductible per person, and a \$2,000 deductible per family.

Both proposals retain a role for employers in providing coverage to their workers. Wicks et al. would require all employers to offer health insurance, but would not require them to contribute to the cost of coverage. Butler also does not require the employers to pay for coverage. However, his proposal does require employers to facilitate coverage for their workers, including administering plan selection and arranging for premium payments and tax credits through payroll withholding.

Although conceptually similar, there are important differences in these two proposals. Some of these differences include:

FIGURE 8: PROPOSALS THAT REPLACE THE TAX EXCLUSION FOR EMPLOYER HEALTH BENEFITS WITH A REFUNDABLE TAX CREDIT

	Stuart Butler	Elliot Wicks, Jack Meyer, and Sharon Silow-Carroll
Universal coverage	Optional: Must have minimum level of coverage to qualify for credit	Mandatory: Tax penalty for non-compliance
Basis for tax credit	Insurance premiums, including employer share plus out-of-pocket spending	Insurance premium, including employer share
Tax credit amount	Credit: 25% of costs up to 5% of income, 40% of costs between 5% and 15% of income, 60% of costs over 15% of income. Maximum of \$5,000 single/\$12,000 family	Below FPL: Amount needed to purchase Medicaid benefits; amounts phased down with income to \$700 single/\$1,500 family for those at or above median income level
Optional fixed credit	People with incomes below \$20,000: \$1,000 per adult; \$500 per child; \$2,500 per family maximum	No provision
Tax exclusion	Eliminates: Income tax and FICA payroll tax exclusions for employer benefits; health expense deduction; and exemptions for health benefits in flexible spending accounts	Eliminates: Income tax exclusion for employer benefits; health expense deduction; and health benefits exemption under "cafeteria plans"; retains FICA payroll tax exclusion
Minimum benefit	<ul style="list-style-type: none"> —Inpatient/outpatient care —Physician care —Prescription drugs —Mental health —20% copay —\$1,000 deductible (\$2,000 family) 	<p>Medicare benefits plus</p> <ul style="list-style-type: none"> —Prescription drugs (average \$15 copay per prescription) —Well-child/maternity care
Employer role	Employers must facilitate (but not contribute to) coverage for workers, including: <ul style="list-style-type: none"> —Health plan choice —Premium payments through payroll withholding —Tax credits through payroll withholding —Automatically enroll in default plan employees that do not select a plan on their own 	Employers must offer coverage but are not required to contribute to the cost of coverage.
Purchasing pool	None	Aggregate purchasing arrangements (APAs) offer selection of health plans. Includes: firms with fewer than 10 workers; current Medicaid-eligible; and others opting into the APA
Disposition of Medicaid	Retained and expanded by providing a block grant to states of \$6.0 billion plus value of unclaimed tax credits for states to use to expand coverage	Dissolved and folded into APA
Insurance regulation	Eliminate health status rating: premiums permitted to vary by age, sex, geography, and family type	Community rate for APA population and all firms with 100 or fewer workers
Default enrollment	None	People without coverage are automatically covered by Medicare when they access health care providers

- *Computation of Credit:* Under the Wicks et al. model, the credit is equal to the amount required to purchase the current Medicaid benefits package for all people below the FPL. The credit is phased down with income so that people with

incomes greater than the median income level receive \$700 for single coverage and \$1,500 for family coverage. Under the Butler proposal, the credit is computed on the basis of total out-of-pocket spending for premiums and health services (copay

amounts, non-covered services) as a percentage of family income.

- *Universal Coverage:* The Wicks et al. proposal requires that all Americans have insurance coverage and imposes substantial tax penalties on those who do not comply. The Butler proposal does not require that everyone have coverage, but it does limit the credit only to those who have insurance that at least conforms to the minimum standard benefits package under his proposal. In addition, employees who do not voluntarily select a plan would be enrolled by their employer in a default plan.
- *Medicaid:* The Wicks et al. proposal terminates Medicaid for the non-Medicare population and subsidizes the purchase of coverage for these individuals through APAs with the tax credits. The Butler proposal retains Medicaid and provides block grants to states to expand coverage for low-income people who are not currently eligible for the program. Funding for these block grants would be based on the unused tax credit amount for people who do not obtain coverage plus an additional \$6.0 billion (amount specified in proposal).

The Wicks et al. proposal would cover nearly all Americans. The number of people without coverage would decline from about 41.9 million to about 1.6 million people (Figure 9). Those who remain uninsured would include undocumented immigrants and very-low-income people who do not file tax returns. It is important to note however, that under Wicks et al., all uninsured people are automatically covered under the augmented Medicare benefits package when they access a health care provider. Thus, the proposal covers virtually all of the health spending it is intended to cover. Although the Butler proposal does not require all people to have insurance, we estimate that it would reduce the number of uninsured by about 26.9 million people.

One of the most important differences between the Wicks et al. and Butler proposals is that the Butler proposal eliminates the tax exemption on health benefits for both the personal income tax and FICA payroll tax, while the Wicks model eliminates only the personal income deduction. This results in a greater incentive to move to

lower-cost health plans under the Butler model. We estimate that the Butler proposal would induce about 36.5 million people to move to lower-cost health plans such as HMOs and high-deductible plans. By comparison, because of the differences in tax incentives, the Wicks et al. proposal would shift about 28.2 million people to lower-cost plans.

FIGURE 9: IMPACT OF REPLACING THE TAX EXCLUSION FOR HEALTH BENEFITS WITH A REFUNDABLE TAX CREDIT IN 2002

	Stuart Butler Proposal	Proposal by: Elliot Wicks, Jack Meyer, and Sharon Silow-Carroll
Reduction in uninsured (millions)	26.9	40.3
Privately insured who shift to lower cost plan (millions)	36.5	28.2
Tax credit payments with administration (billions)	\$222.4	\$314.4
Block grants to states (billions)	\$9.4	—
Federal cost less offsets (billions)	\$236.1	\$230.8
Federal cost after elimination of the health benefits tax exclusion (billion)	\$105.1	\$154.4

Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

Total tax credit payments (including administration) would be \$222.4 billion under the Butler proposal and \$314.4 billion under the Wicks et al. proposal. We estimate that there would be an additional \$9.4 billion in block grant payments to the states under the Butler proposal. (This brings total federal spending before offsets to \$231.8 billion under the Butler proposal.) Under both proposals, these expenditures are largely offset by increased tax revenues resulting from elimination of the income tax exclusion. Costs under Wicks et al. also would be partly offset by the funding that otherwise would have been used for the Medicaid program.

Total federal costs less offsets would be about \$236.1 billion under the Butler model and \$230.8 billion under the Wicks et al. proposal. Federal costs net of elimination of the health benefits tax exclusion would be \$105.1 billion for the Butler proposal and \$154.4 billion under the Wicks et al. proposal. The difference in net costs under the two proposals is roughly equal to the revenue loss from the FICA payroll tax exemption that is retained in the Wicks proposal. ■

COMMENTARY BY ELLIOT WICKS, JACK MEYER, AND SHARON SILOW-CARROLL

An oversight on our part when we wrote the proposal causes the Lewin Group analysis to overstate the portion of the federal cost that would have to be financed through income taxes or general revenues. The Lewin analysis correctly notes that we would eliminate the income tax provision that makes employer-paid premiums not taxable as personal income for employees, and that we did not explicitly eliminate the tax exemption for Social Security and Medicare taxes. Our *intent*, however, was that employer-paid premiums would be taxed exactly like employee wages—to create neutral incentives between receiving compensation as wages or health premiums—and would thus be subject to *both* income and FICA taxes.

Had we been more complete in spelling out our intent, the portion of the net new federal spending that would have to be financed by general revenues or income taxes would presumably have been reduced by about one-third, from about \$155 billion to about \$105 billion. We come to this conclusion because the Lewin analysis (Figure 14) shows that the Butler proposal, which eliminates the tax exemption for both income and FICA taxes, generates about \$50 billion more than ours does. Of course, the net new federal spending total would be unaffected, but the amount of new taxes needed would be reduced by \$50 billion.

We believe that the Lewin analysis probably understates one source of saving for our proposal. While Lewin does not characterize our approach as a managed competition approach, in writing the proposal we intentionally structured the incentives in such a way as to foster managed competition very much along the lines outlined by other proposals that rely on this form of competition to constrain costs. We believe that our proposal would generate substantial additional savings from this source that are not recognized in the Lewin analysis.

One final point regarding the number of people that would be covered by our plan: Our proposal, alone among those analyzed, would achieve true *universal coverage* in the sense that every legal resident seeking medical care would have the cost of his or her medical services paid for by either their own coverage or by the fallback Medicare system. The Lewin analysis acknowledges this but does not count as insured the people who do not enroll prior to seeking care. While it may be technically accurate to count them as “uninsured,” it is not accurate to view them as being without coverage. The important point is that lack of coverage would no longer be a barrier to deter anyone from receiving needed medical care.

Tax-Financed System

Richard Kronick and Thomas Rice propose that state governments individually devise programs for financing a minimum level of coverage for all of their legal residents. The federal government would support the states with financing raised from a payroll tax assessed on all employers and employees. In turn, the federal government would mandate that states create such programs within minimum specifications, monitor the state programs, and impose financial penalties for noncompliance. States could establish a single-payer health plan or create an insurance pool that offers a selection of private health plans.

Each state would develop a program providing a standardized benefit package to all legal residents in their jurisdiction except Medicare recipients and people covered under CHAMPUS. States would be required to meet certain requirements before they receive funding. Each state must have a program covering at least 98 percent of legal residents (Figure 10), and at least one zero-premium health plan must be offered in all areas of the state. All health plans in the state's program, including those with zero premiums, must include a comprehensive benefits package (no requirement for long-term care). The benefits package must include low cost sharing such as a \$10 copayment for all physician and hospital outpatient services and a \$10 copayment for each prescription. There would be no deductible.

This benefits design simplifies program administration in several ways. The requirement that a zero-premium plan be available to all people in the program eliminates the need to create a program to provide premium subsidies to lower-income people. The use of low cost sharing also reduces or eliminates the need to create a program to subsidize cost sharing as is required under other proposals. Also, in states offering a choice of health plans, individuals would pay the full additional cost of enrolling in more costly plans, which would create incentives for individuals to enroll in cost-efficient plans.

FIGURE 10: MAJOR PROVISIONS OF KRONICK AND RICE TAX-FINANCED PROPOSAL

	Proposal Provisions Richard Kronick and Thomas Rice
Source of coverage	All of the non-Medicare population would obtain coverage through a state-operated program funded with a payroll tax
Form of coverage	States can establish either a single-payer system or provide a selection of alternative health plans in each area
Minimum coverage requirement	States must cover at least 98% of the population (excluding undocumented immigrants)
Minimum benefits	State health plans must cover <ul style="list-style-type: none"> —Medically necessary inpatient and outpatient care —Physician services —Acute nursing and home health care —Mental health care (in parity with physician care) —Preventive services —Prescription drugs —Durable medical equipment
Maximum Co-Payments	\$10 co-payment for physician and outpatient services and a \$10 co-payment for each prescription; no deductible
Managed competition	State must provide at least one zero premium plan (that is consumer pays the full cost of selecting a more costly plan) in all areas of the state
Financing	Payroll tax equal to 95% of current spending for <ul style="list-style-type: none"> —Current employee and employer contributions for employer insurance —Non-group coverage for workers and dependents —Out-of pocket spending for workers and dependents
Employers of low-wage workers	Payroll tax rate reduced by two percentage points for employers where average wage is under \$8.00 per hour
Retiree benefits	Employers with retiree health benefits would be taxed on windfall
Federal payments to states	The federal contribution to each state would be equal to projected health spending in the state less the state's required contribution <p>State contribution equals 90% of</p> <ul style="list-style-type: none"> —Current Medicaid/S-CHIP spending for currently covered services that would be covered under state program —State spending for Medicare dual-eligible population —Medicaid/S-CHIP spending for children for services not covered under new state program

The program would eliminate the linkage between employment and insurance coverage, except to the extent that employers must pay a payroll tax. This enables individuals to change jobs without changing to another insurance plan. De-linking coverage from employment would also reduce administrative costs by aggregating coverage for each state into a single insurance group.

The federal government would collect a payroll tax levied on all employers and employees. The rate would be set at the level that would raise an amount equal to 95 percent of what is currently spent nationally for benefits covered under the new federally imposed minimum package. We estimate that the total payroll tax rate would be 9.4 percent, with employers paying 7.0 percent and workers paying 2.4 percent.⁸ The employee payroll tax contribution would be in pre-tax dollars for all workers. In addition, corporations with retiree health obligations would be taxed on their windfall gain resulting from the government's assumption of health benefits for early retirees (that is, non-Medicare retirees).

Medicaid would continue as under the current program for long-term care services, including nursing home care, home health, and community-based services. The Medicare dual eligible population would be covered under a new program covering non-long-term care services, including prescription drugs, copayments, deductibles, and Part B premiums. The program would be fully funded by the federal government. All other Medicaid recipients would be covered under the new state programs. Federal obligations to Medicaid and SCHIP for services now covered under the state programs would be available to fund the program.

The federal government would disburse to the states the difference between their estimated program costs and each state's expected contribution. The states' contribution would be equal to 90 percent of the state's current spending for the acute care services (that is, excluding long-term care) under the Medicaid program except for the aged

and disabled populations.⁹

We estimate that virtually all Americans would be insured under the program. Those who remain uninsured would be undocumented immigrants and lower-income non-workers who are difficult for states to reach. The various state programs would cover about 240.9 million people (Figure 11). The total cost of the program (including state and federal shares) net of offset would be about \$610.6 billion if fully implemented in 2002. The federal share of costs would be \$577.5, with states paying \$33.1 billion.

FIGURE 11: IMPACTS OF KRONICK AND RICE TAX-FINANCED PROPOSAL IN 2002

Tax-Financed Plan: Richard Kronick and Thomas Rice	
Sources of Coverage (millions)	
Reduction in uninsured (currently 41.9 million people)	40.3
Public plan enrollment	240.9
Program Costs (billions)	
Total program costs (state and federal)	\$610.6
Federal share	\$577.5
State share	\$33.1
Federal Program Funding (billions)	
Federal cost net of offsets a/	\$551.7
Payroll tax revenues	\$498.7
Total	9.4%
Worker share	2.4%
Employer share	7.0%
Employer tax on retiree savings	\$6.4
Amount financed with income tax	\$46.6
Net New Employer Costs per Worker per Year	
Currently insuring employers	\$197
Non-insuring employers	\$1,758

a/ Offsets include Medicaid program savings of \$47.7 billion less increases in other government program costs of \$1.3 billion. Offsets are reduced by the amount of the tax loss resulting from the wage effects attributed to increased employer costs under the proposal (\$20.6 billion).

Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM)

⁸ Employers whose average employee earns less than \$8 per hour would pay a payroll tax two percentage points lower than the standard tax rate.

⁹ Details of this computation are presented in the appendix describing this proposal.

The federal share of costs for the program (\$577.5 billion) would be partly offset by savings to other government programs. The total federal cost of the program less these offsets would be about \$551.7 billion. The program would be funded with payroll tax revenues of \$498.7 billion, a tax on employers for retiree savings of about \$6.4 billion, and an increase in the personal income tax of about \$46.6 billion.

The impact of the program on employers would vary, depending on the earnings level of their workers and the cost of health benefits currently provided to their workers.

Firms that currently offer insurance would on average see an increase in costs of about \$197 per worker per year. Costs for firms that do not now provide coverage would be about \$1,758 per worker per year. ■

COMMENTARY BY RICHARD KRONICK AND THOMAS RICE

John Sheils and Randy Haught have provided comparative analyses of a widely disparate set of proposals, and we appreciate their care, effort, and good judgment. We comment here on three aspects of their work: a curious treatment of changes in state tax liability that affects the analysis of all of the proposals; the characterization and modeling of our proposal as “managed competition;” and the limitations of this sort of modeling exercise.

First, we think it is a mistake that the analysis treats changes in state tax liability differently than changes in federal tax liability or employer payments. Changes in the latter are assumed by Sheils and Haught to be “financed” by individuals (Figure 19). However, there is not a similar assumption about changes in state income tax liability; proposals that increase state liabilities (for example, Feder et. al. and Pauly) are not assumed to result in increases in state income tax payments. Conversely, proposals such as ours that decrease state financial liability are not assumed to result in lower state income tax payments. This asymmetric treatment of state and federal tax liabilities unfairly disadvantages proposals, such as ours, that envision an initial decline in state liabilities.

Second, in modeling the effects of our proposal, Sheils and Haught assume that all states would adopt the “managed competition” model of contracting, with competing private health plans, rather than a single-payer model. Although the actions of politicians are difficult to predict, we doubt that all 50 states would adopt managed competition systems. Many constituencies dislike managed care. We would expect at least some states to implement variants of single-payer systems, and, if these systems produce positive outcomes, for such systems to spread. In other work, Sheils and Haught assume that single-payer systems will result in substantial reductions in administrative costs. (See, for example, The Lewin Group, *Cost and Coverage Analysis of Nine Proposals to Expand Health Insurance Coverage in California*, Final Report prepared for the California Health and Human Services Agency, April 2002.) The modeling results therefore should provide at least partial credit for “single-payer” savings.

Third, regarding the limited ability of modeling to provide guidance to policy, we are struck that Sheils and Haught’s analyses of our proposal would be virtually identical if we had proposed an entirely federally financed and administered system rather than the state-based approach we did propose. State-based accountability under a federal framework is a key of our proposed system, yet the inherent limitations of the modeling exercise force them to largely ignore this feature of our work.

Comparison of Program Impacts

One of the objectives of this analysis was to estimate the impact that these health reform proposals would have on various stakeholder groups, including providers, state and local governments, employers, and households. As discussed above, HBSM was used to estimate the change in the number of uninsured people and the net cost of these proposals to the federal government. In addition, we estimated the impact on total national health spending, which reflects increased health services utilization for the uninsured, changes in provider payment levels, and administrative costs.

We also estimated the impact of these proposals on spending and revenues for state and local governments including spending under state safety-net programs, income tax revenues, and state and local government worker benefits. In addition, we estimated the impact on employers by size of firm and current insuring status. We also estimated the impact on household out-of-pocket spending for health insurance and health services for families by income level, age, and current insured status. These data are provided in the detailed analyses of these proposals presented in the appendices to this report.

In this section, we present a summary comparison of our estimates of the impact of the various proposals on these stakeholder groups. As discussed above, to facilitate these comparisons, we have used uniform data and assumptions to model each proposal (see Appendix A). This is designed to assure that differences in estimates across proposals are attributed to differences in program design rather than mere inconsistencies in assumptions. Our analyses of the impacts of these proposals on these stakeholder groups are presented in the following sections:

- Coverage effects;
- National health spending;
- Federal costs;
- State and local governments;
- Private employers; and
- The household sector.

Coverage Effects

Figure 12 compares coverage effects for each proposal. In general, the proposals that would expand coverage voluntarily would cover substantially fewer people than those that include a mandate for people to obtain coverage. The incremental reform proposals introduced by Feder et al. and Pauly—that is, proposals that expand voluntary coverage under existing public and private programs—would cover between 12 million and 21 million of the 41.9 million people who do not have coverage. The proposals to create voluntary subsidized coverage through newly created insurance pools—that is, Singer et al., Gruber, and Holahan et al.—would cover between 12 million and 15 million of the uninsured.

We estimate that the proposals that mandate coverage for some or all of the population would cover at least 88 percent of the uninsured. For example, the two pay-or-play proposals introduced by Hacker and Weil would each cover about 37 million people. This reflects the fact that these proposals would require all employers to either cover all of their workers or pay a payroll tax that automatically covers their workforce under a newly established public program. These proposals also require the non-working population to obtain insurance and implement a default enrollment system to cover those who can be identified as not having insurance. However, because these proposals impose no penalty for failing to enroll, we assumed there would be less than full enrollment among the non-working population (including workers during periods of non-employment) under these proposals.

The Wicks et al. proposal would cover about 40.3 million people, leaving only about 1.6 million people without coverage. Wicks et al. also use a mandate and a default enrollment system similar to those proposed by Hacker and Weil et al. However, compliance with the coverage mandate in the Wicks et al. proposal is expected to be greater because it includes substantial tax penalties for people who do not maintain coverage.¹⁰

¹⁰ Penalties equal the average premium by family type for each of the months they went without insurance in the prior year, plus a 10 percent penalty.

FIGURE 12: CHANGES IN PRIMARY SOURCES OF HEALTH INSURANCE UNDER REFORM PROPOSALS (MILLIONS)

	Number Uninsured	Private Coverage Outside Insurance Pools	Private Coverage through New Insurance Pools/Exchanges	New Public Plan	Medicare	Medicaid/S-CHIP	CHAMPUS/Other
CURRENT SYSTEM TOTALS							
Current System (baseline)	41.9	173.2	N/A	N/A	33.8	27.4	3.6
CHANGES IN COVERAGE							
Incremental Reforms							
Public Coverage Expansion with Employer Tax Credit: Feder, Levitt, O'Brien, and Rowland	(12.0)	(7.3)	—	—	—	19.3	—
Adaptive Tax Credit Plan: Pauly	(20.5)	9.4	—	—	—	11.1	—
Voluntary Insurance Pool Proposals							
An Insurance Exchange Approach: Singer, Garber, and Enthoven	(11.8)	(62.9)	74.7	—	—	—	—
Private Public Partnership: Gruber	(14.5)	(117.3)	157.5	—	—	(25.3)	(0.4)
Federal/State Approach: Holahan, Nichols, and Blumberg	(15.2)	(85.1)	126.1	—	—	(25.3)	(0.5)
Pay-or-Play Models							
Medicare Plus: Hacker	(37.0)	(51.0)	—	113.2	—	(25.5)	—
The Medical Security System: Weil	(36.9)	(0.5)	64.5	—	—	(27.1)	—
Proposals to Replace Tax Exclusion with Tax Credits							
Tax Credits with Insurance Pool: Wicks, Meyer, and Slow-Carroll	(40.3)	(50.0)	117.4	—	—	(27.1)	—
Variable Tax Credits: Butler	(26.9)	23.3	—	—	—	3.6	—
Tax-Financed Health Care System							
A State-Based Approach: Kronick and Rice	(40.3)	(173.2)	240.9 ^{a/}	—	—	(27.4)	—

^{a/} The Kronick et al. proposal permits states to adopt either a new public plan—such as a single-payer model—or provide private coverage through an insurance pool offering a choice of health plans. For illustrative purposes, we assumed that all states would adopt a private insurance pool model.

Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

The Kronick and Rice proposal would also achieve nearly full coverage under its tax-financed proposal. This is because all individuals living in an area can be enrolled in the system for life based on their Social Security number. Also, people do not have to pay a premium to become covered because the program is fully funded through taxes that are automatically collected through payroll withholding.

The Butler proposal would cover about 26.9 million of the uninsured even though it does not include a mandate to have insurance. This is because Butler would implement an automatic enrollment process administered by all employers regardless of whether the employer contributes to the cost of coverage. Under this system, workers who did not voluntarily select a health plan would be enrolled in a default health plan unless they file a form with the state saying they did not want the insurance. Available evidence indicates that the automatic enrollment process increases participation in employee benefits programs. We estimate that automatic enrollment would more than double the number of workers in non-insuring firms who would acquire non-group insurance, resulting in substantial enrollment despite the absence of a coverage mandate.

Figure 12 also shows changes in the number of people with various types of private and public insurance, including newly created public programs under these proposals. The Feder et al. and the Pauly proposals would expand coverage largely through expansions in the current Medicaid and S-CHIP programs. Six of the proposals would create insurance pools offering a selection of private health plans competing for enrollment based on price and other factors such as health plan network and quality. The Hacker proposal is the only one that creates a new public insurance program, which in his proposal is modeled on the Medicare program.¹¹ The Butler proposal provides tax credits for purchases of health insurance in the private market without creating publicly sponsored insurance pools or creating/ ex-

panding public health plans.

National Health Spending

Health spending in the United States is projected to reach about \$1.5 trillion for 2002. This includes total expenditures for health services provided through government programs and private insurance as well as the cost of administering coverage under public and private insurance programs, research, construction, and public health activities. Under all of these proposals, there would be a net increase in national health expenditures as uninsured people become covered and benefits are improved for many of those who are currently insured.

The change in national health spending under these proposals is an important measure for comparing health reform proposals. It shows how these proposals affect the total amount that society would pay for health services, regardless of who would pay for it. In this study, we estimated the changes in spending under each proposal for the following:

- Health services utilization for newly covered people;
- Changes in provider reimbursement;
- Savings from changes in consumer incentives; and
- Changes in administrative costs.

Health Services Utilization for Newly Covered People

We estimated the increase in health services utilization for both newly insured people and currently insured people who become covered for more services as a result of each proposal. In this analysis, we have assumed that utilization of health services for newly insured people would, on average, increase to the levels observed among insured people with similar demographic and health status characteristics.¹² Similarly, people who become covered under a more comprehensive benefits packages under these proposals are assumed to use newly covered services (for example, prescription drugs, dental care etc.) at the levels observed among people who are currently covered for these services.

¹¹ The Kronick and Rice proposal permits states to cover the non-Medicare population through either a public program or a publicly sponsored insurance pool with competing private health plans. For illustrative purposes, we have assumed that all states adopt the insurance pool approach.

¹² Using these assumptions, we estimate that utilization of health services for currently uninsured people would increase by about 70 percent once they become insured.

These are simplifying assumptions that encompass complex changes in how people will change their utilization of health services as they become insured. For example, the increase in access to primary care for this population would probably result in a reduction in preventable emergency room visits and hospitalizations. However, we would also expect a general increase in the use of elective services such as primary care, corrective orthopedic surgery, advanced diagnostic tests, and other care that the uninsured either forgo or delay. Our assumptions encompass these changes by assuming that utilization of health services for newly insured people would “look like” utilization of such services for insured people with similar characteristics.

We estimate that the cost of this increased utilization would range between about \$14.3 billion under the Singer et al. proposal to about \$34.8 billion under the Wicks et al. proposal (Figure 13). The increase in health services utilization under these proposals generally varies in proportion to the number of newly insured people under each proposal.

Changes in Provider Reimbursement

The impact of these proposal on health spending is also affected by provider payment levels for services. Under these proposals, provider payment levels are affected in two ways. First, under all of the proposals, providers would be paid for services provided to newly insured people that otherwise would have been provided free as uncompensated care. Second, under some of these proposals, people are moved to or from public programs where provider reimbursement levels are generally lower than under private plans by 20 percent or more, depending on the type of service.

In this study, we estimated the total change in provider reimbursement due to reduced uncompensated care and shifts to or from public health plans under these proposals. However, we assume that due to market forces, some of the net change in reimbursement would be negotiated back to private payers in the form of reduced cost shifting. Based on prior studies of cost shifting, we assume that 40 percent of savings from reduced uncompensated care and provider payment increases would be passed on to privately insured people in the form of reduced

cost shifting. Similarly, we assume that 40 percent of reductions in provider reimbursement for services, such as a shift from private coverage to public coverage, are passed on to privately insured people as an increase in the cost shift.

The increases in provider reimbursement under these proposals vary from about \$4.7 billion under the Feder et al. and Pauly proposals to about \$16.1 billion under the Weil proposal. Provider payment increases are largest under the Gruber, Wicks et al., Holahan et al., and Weil proposals because these plans would cover much of the Medicaid population under private health plans through the insurance pools created under these proposals.

Savings from Changes in Consumer Incentives

Five of the proposals are designed to reduce costs by using a “managed competition” model. In general, managed competition gives people access to a selection of health plans competing on the basis of price and quality. Employers are permitted to contribute to the cost of health benefits, but the contribution must be a fixed amount so that individuals face the full cost of selecting a more costly health plan. The managed competition model is used in the exchanges and coverage pools created under the proposals by Singer et al., Gruber, Holahan et al., Weil, and Kronick and Rice.¹³ In addition, the Holahan et al. proposal requires employers to make a fixed contribution for all of their workers, including those taking coverage outside the voluntary purchasing pool.

We estimated the impact this would have on health spending based on studies of the impact of changes in the price for insurance on managed care enrollment and the amount saved in typical managed care plans. The savings from managed competition under these proposals ranges between \$3.6 billion under Weil and \$13.4 billion under Holahan et al. Managed competition savings generally vary with the portion of the population that is covered in an arrangement where the fixed employer contribution is required.

¹³ The Singer et al. and Gruber proposals would also cap the value of the tax exemption for employer health benefits to increase incentives to enroll in less costly health plans.

FIGURE 13: CHANGES IN NATIONAL HEALTH SPENDING UNDER REFORM PROPOSALS IN 2002

	A	B	C	D	B-C+D=E	F	G=E+F	G/A	G/279.9 million
	Reduction in Uninsured (millions)	Utilization for Newly Covered (billions) ^{a/}	Savings due to Changes in Incentives (billions) ^{b/}	Changes in Provider Reimbursement (billions) ^{c/}	Total Change in Spending for Health Services (billions)	Change in Administrative Costs (billions)	Net Change in National Health Spending (billions)	Change in National Health Spending per Newly Insured Person	Change in National Health Spending per Person
Incremental Models									
Public Coverage Expansion with Employer Tax Credit: Feder, Levitt, O'Brien, and Rowland	12.0	\$19.9	—	\$4.7	\$24.6	\$1.5	\$26.1	\$2,175	\$93
Adaptive Tax Credit Plan: Pauly	20.5	\$24.0	—	\$4.7	\$28.7	\$7.9	\$36.6	\$1,785	\$131
Voluntary Insurance Purchase Pools									
An Insurance Exchange Approach: Singer, Garber, and Enthoven	11.8	\$14.3	\$6.3	\$8.9	\$16.9	\$6.1	\$23.0	\$1,949	\$82
Private Public Partnership: Gruber	14.5	\$22.9	\$9.0	\$14.1	\$28.0	\$8.7	\$36.7	\$2,548	\$131
Federal/State Approach: Holahan, Nichols, and Blumberg	15.2	\$22.9	\$13.4	\$14.5	\$24.0	\$10.0	\$34.0	\$2,237	\$121
Pay-or-Play Proposal									
Medicare Plus: Hacker	37.0	\$30.3	—	\$0.0	\$30.3	\$2.0	\$32.3	\$873	\$115
The Medical Security System: Weil	36.9	\$30.3	\$3.6	\$16.1	\$42.8	\$14.4	\$57.2	\$1,550	\$204
Proposals to Replace the Tax Exclusion with Tax Credits									
Tax Credits with Insurance Pool: Wicks, Meyer, and Sillow-Carroll	40.3	\$34.8	\$8.5	\$14.3	\$40.6	\$11.5	\$52.1	\$1,293	\$186
Variable Tax Credits: Butler	26.9	\$25.6	\$17.0	\$5.7	\$14.3	\$9.2	\$23.5	\$873	\$84
Tax-Financed Health Care System									
A State-Based Approach: Kronick and Rice	40.3	\$33.0	\$13.0	\$13.7	\$33.7	(\$1.0)	\$32.7	\$811	\$116

^{a/} Includes increased utilization for newly insured people and increased utilization among currently insured people who are newly covered for certain services (that is, dental, prescription drugs etc.).

^{b/} Includes reductions in health service utilization under managed competition and from charges in the tax treatment of employer benefits.

^{c/} Reflects reduction in provider uncompensated care expense and shifts to and/or from public health plans with lower rates of reimbursement for services.

Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

The Wicks et al. and Butler proposals also seek to change consumer incentives by eliminating the tax exclusion for employer health benefits and replacing it with a tax credit. As discussed above, under Wicks et al., the tax credit is a fixed-dollar amount that does not vary with the premium amount (unless the insurance costs less than the credit amount). This contrasts with the current tax exemption, which does vary with the premium amount. Switching to the credit approach eliminates the existing tax incentive to purchase more comprehensive coverage, resulting in reduced health services utilization. The Butler plan provides the credit for both insurance premiums and out-of-pocket spending.¹⁴ This eliminates the tax incentive to consume care through insured arrangements rather than through direct purchases of services from providers, resulting in increased consumer price sensitivity at the point of service.

The reduction in health spending would be \$8.5 billion under the Wicks proposal and \$17.0 billion under the Butler proposal. There are two reasons why the Butler proposal shows larger savings. First, the minimum benefits package under Wicks et al. is substantially more comprehensive than the high-deductible plan required as a minimum under Butler. Second, while both proposals eliminate the income tax exclusion for employer health benefits, the Butler plan also eliminates the exclusion for Social Security taxes, resulting in a greater effect on coverage and utilization.

Changes in Administrative Costs

These proposals would also have significant impacts on administrative costs in the system, including:

- The insurer cost of administering coverage for newly insured people (that is, claims processing general administration, marketing costs and profit);
- The cost of administering the various purchasing pools created under some of the proposals (that is, enrollment processing, solicitation of health plan bids, contract negotiation, and marketing); and

- The cost of administering income-tested subsidies for people receiving subsidies under these proposals.

The change in administrative costs would vary from savings of about \$1.0 billion under Kronick and Rice to an increase of up to \$14.4 billion under the other proposals. This reflects the fact that the Kronick and Rice proposal would reduce administrative costs by going to a tax-financed system that does not require premium collections or the premium subsidies found in other proposals. By comparison, the other proposals would often expand on small-group and individual coverage where administrative costs are typically highest.

Impact on Per Capita Health Spending

Figure 13 also presents estimates of the average increase in national health spending per newly insured person. The smallest increase in spending per newly insured person was \$811 under the Kronick and Rice proposal, which reflects the impact of the changes in consumer incentives under the proposal that would lead to reduced health services utilization. The average increase in health spending per newly insured person under the other proposals ranged from about \$873 under the Hacker proposal to about \$2,548 under the Gruber proposal.

Federal Spending

The federal cost of the various programs created under these proposals ranges from a low of \$37.1 billion under the Feder et al. incremental proposal to a high of \$577.5 billion under the Kronick and Rice tax-financed program (Figure 14). Program costs include the cost of any benefits or subsidies provided under these programs less premium collections (if applicable). Program costs also include the cost of administering subsidies and coverage for affected people.

The federal share of the cost for these programs is equal to total program costs less offsets to other programs. Federal costs net of these offsets vary from \$34.1 billion under Feder et al. to \$551.7 billion under Kronick and Rice.

Figure 14 presents the sources of funding for these programs, including payroll taxes, state maintenance-of-effort payments, reduction or elimination of the health benefits tax exclusion, and increases in

¹⁴ The Butler proposal requires people to have at least a minimum level of insurance coverage (a plan covering basic services with a \$1,000 deductible) to qualify for the credit; this is to prevent people from discontinuing coverage and just using the credit to cover direct purchases of health services.

FIGURE 14: CHANGES IN FEDERAL HEALTH SPENDING AND SOURCE OF FINANCING UNDER HEALTH REFORM PROPOSALS

	Total Federal Share of Spending			Offsets			Financing Sources			Net New Federal Spending per Newly Insured Person
		Savings Offsets from Replacing/Reducing Current Subsidy Programs a/	Wage Effect Tax Offsets	Other Offsets	Net New Federal Spending	Eliminating/Capping Tax Exclusion	Payroll Tax	Income Tax or General Revenues	State Maintenance of Effort	
Incremental Reforms										
Public Coverage Expansion with Employer Tax Credit: Feder, Levitt, O'Brien and Rowland	\$37.1	—	\$3.0	—	\$34.1	—	—	\$34.1	—	\$2,842
Adaptive Tax Credit Plan: Pauly	\$89.8	—	\$0.1	—	\$89.7	—	—	\$89.7	—	\$4,376
Voluntary Insurance Pool Proposals										
An Insurance Exchange Approach: Singer, Garber, and Enthoven	\$109.3	—	\$6.2	\$0.3	\$102.8	\$8.4	—	\$94.4	—	\$8,712
Private Public Partnership: Gruber	\$247.6	\$37.5	\$19.5	\$0.1	\$190.5	\$12.0	—	\$149.1	\$29.4	\$13,137
Federal/State Approach: Holahan, Nichols, and Blumberg	\$156.0	\$13.9	\$12.1	\$2.6	\$127.4	—	—	\$127.4	—	\$8,382
Pay-or-Play Models										
Medicare Plus: Hacker	\$285.3	\$38.0	\$3.1	\$2.3	\$241.9	\$1.7	\$126.0	\$87.5	\$26.7	\$6,538
The Medical Security System: Weil	\$204.2	\$47.4	(\$4.5)	\$0.4	\$160.9	—	\$64.7	\$58.9	\$37.3	\$4,360
Proposals to Replace Tax Exclusion with Tax Credits										
Tax Credits with Insurance Pool: Wicks, Meyer, and Silow-Carroll	\$314.4	\$84.1	(\$0.8)	\$0.3	\$230.8	\$76.4	—	\$154.4	—	\$5,727
Variable Tax Credits: Butler	\$231.8	—	(\$2.8)	(\$1.5)	\$236.1	\$131.0	—	\$105.1	—	\$8,777
Tax-Financed Health Care System										
A State-Based Approach: Kronick and Rice	\$577.5	\$47.7	(\$20.6)	(\$1.3)	\$551.7	—	\$505.1 a/	\$46.6	—	\$13,689

a/ Also includes \$6.4 billion in tax on savings for retiree coverage under the proposal.

Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

federal income taxes. In this study, we assumed that federal spending in excess of specified revenues would be funded through an increase in the federal personal income tax payments sufficient to pay for the program (the effect this has on households is discussed below).¹⁵

One way to compare the cost of these proposals is in terms of the net new federal cost per newly insured person, which ranges from \$2,842 under the Feder et al. proposal to \$13,689 under the Kronick and Rice model.

Evaluating these proposals purely in terms of the net federal cost per newly insured person ignores the fact that some of them are designed to achieve more than just reducing the number of uninsured. For example, some of the proposals are designed to shift the public into programs with incentives to control health spending growth. Some proposals also achieve improved equity in federal subsidies for health coverage such as extending tax benefits to people who do not have access to employer coverage. (Employer-sponsored coverage is tax-exempt under current law.) Thus it is important to look as well at the overall effect on health care costs and the impact on various stakeholders.

State and Local Government Impacts

All of these proposals would have a significant impact on health spending for state and local governments. States pay for about 44 percent of the Medicaid program (\$95.8 billion) and provide about \$36.2 billion in health benefits through public hospitals, public clinics, and other state programs. Some of these proposals would expand Medicaid/S-CHIP-like programs, resulting in increased state spending. Other proposals require only a maintenance-of-effort contribution to the cost of newly established programs, resulting in little net change in state spending. Also, the cost of state and local safety net programs serving the medically indigent would be reduced as currently uninsured people become covered.

State and local tax revenues also would be affected by these reforms. For example, programs

that increase employer-sponsored coverage are expected to slow wage growth for affected workers, resulting in a reduction in income and payroll tax revenues for states and localities with these types of taxes. In addition, proposals that require employers to contribute to the cost of insurance for workers and dependents can increase costs for state and local employee benefits programs. This includes the effect of minimum benefits and employer contribution standards for government workers and the cost of covering those government workers who are not currently eligible under the state employees' health benefits plans (for example, part-time and temporary workers).

The incremental expansion proposals introduced by Feder et al. and Pauly would increase eligibility under current Medicaid/S-CHIP programs. Under these proposals, states would be required to contribute to the cost of this coverage, resulting in an increase in state spending of between \$12 billion and \$13 billion under both proposals (Figure 15). (Feder et al. would use an enhanced federal matching rate.) There would be little change in state Medicaid spending under the other proposals because they require only maintenance of effort for current state Medicaid/S-CHIP funding.

Each proposal would reduce expenditures for health services under safety net programs. As uninsured people obtain coverage, many would start to use private physicians and hospitals, resulting in reduced safety net expenditures for this population. In addition, safety net providers would be able to obtain reimbursement for services provided to newly insured people who continue to use these providers. With the exception of the Kronick and Rice proposal, savings to safety net providers would range between \$6.6 billion under Feder et al. to \$13.5 billion under Holahan et al. Safety net savings under the Kronick and Rice proposal would be about \$23.4 billion, which is about \$10.0 billion more than under any of the other proposals. The reason for this is that their proposal requires that all of the non-Medicare population be covered under a broad benefits package with little cost sharing. This increases the share of the charge for these services that would be covered by insurance for both newly insured people and currently insured people who are also using these providers.

These reform proposals would potentially affect state income, and payroll tax revenues in two ways.

¹⁵ Federal tax payments were proportionally increased for families at all income levels.

FIGURE 15: CHANGES IN HEALTH SPENDING FOR STATE AND LOCAL GOVERNMENTS UNDER REFORM PROPOSALS IN 2002 (BILLIONS)

	A	B	C	D	E	A+B+C-D-E
	Medicaid/S-CHIP Spending	Safety Net	Other Programs	Changes in Employer Benefits Tax Exclusion	Wage Effect Tax Revenue Increase/(Decrease) ^{a/}	Net Cost (Savings)
Incremental Proposals						
Public Coverage Expansion with Employer Tax Credit: Feder, Levitt, O'Brien and Rowland	\$12.6	(\$6.6)	—	—	\$0.3	\$5.7
Adaptive Tax Credit Plan: Pauly	\$13.0	(\$10.3)	—	—	\$0.0	\$2.7
Voluntary Insurance Pool Proposals						
An Insurance Exchange Approach: Singer, Garber, and Enthoven	—	(\$13.4)	(\$0.5)	\$0.3	\$0.4	(\$14.6)
Private Public Partnership: Gruber	—	(\$7.6)	(\$0.5)	\$0.7	\$1.2	(\$10.0)
Federal/State Approach: Holahan, Nichols, and Blumberg	\$2.8	(\$13.5)	(\$0.3)	—	\$1.5	(\$12.5)
Pay-or-Play Models						
Medicare Plus: Hacker	—	(\$10.8)	—	\$0.2	\$0.5	(\$11.5)
The Medical Security System: Weil	\$2.3	(\$9.4)	—	—	(\$2.4)	(\$4.7)
Proposals to Replace the Tax Exclusion with Tax Credits						
Tax Credits with Insurance Pool: Wicks, Meyer, and Silow-Carroll	(\$1.9)	(\$10.1)	(\$0.6)	\$14.6	\$0.3	(\$27.5)
Variable Tax Credits: Butler	—	(\$7.7)	—	\$13.7	\$0.0	(\$21.4)
Tax-Financed Health Care System						
A State-Based Approach: Kronick and Rice	(\$3.7)	(\$23.4)	(\$0.7)	—	(\$3.4)	(\$24.4)

a/ Increases in tax revenues are counted as an offset to program costs while decreases are counted as a program cost.

Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

First, several of these plans require employers to contribute to the cost of covering all of their workers. Economic theory and evidence indicates that these increases in employer costs would be passed on to workers in the form of reduced wage growth resulting in a corresponding reduction in revenues from state and local income taxes.

Second, several of these proposals would either limit or eliminate the tax exclusion for employer-sponsored health benefits. This would lead to an automatic increase in income tax revenues in states that base tax payments on the amount of taxable income reported to the federal government.¹⁶ For example, states would see an increase in tax reve-

nues of about \$14.6 billion under Wicks et al. and about \$13.7 billion under Butler, because these proposals eliminate the tax exclusion for employer-sponsored health benefits. The gains in tax revenue are substantially smaller under the proposals that only cap the exclusion (that is, Gruber, Singer et al., and Hacker). The net cost of these reforms to state and local governments is equal to the sum of changes in Medicaid/S-CHIP spending, tax revenues, and safety net program savings. States would see a net increase in spending under Feder et al. (\$5.7 billion) and Pauly (\$2.7 billion). All other proposals would result in net savings ranging between \$4.7 billion under Weil and \$27.5 billion under Wicks et al.

Impact on Private Employers

We estimate that private employers will spend about \$284.3 billion on health benefits in 2002. This includes

¹⁶ Many of the states with income taxes base taxable income on federal adjusted gross income (AGI), which, under these plans, would be the taxable value of employer-sponsored health benefits.

total benefits and insurer administrative costs less employee premium contributions. Private employer spending (that is, \$284.3) includes spending of about \$264.7 billion for workers and dependents and \$19.5 billion for retirees. Figure 16 presents the changes in employer health spending for insuring and non-insuring firms under each of the proposals.

All of the proposals included in this study affect private employer health spending in some way. For example, the Feder et al. incremental reform proposal would reduce spending for firms that currently provide coverage by an average of about \$128 per worker (Figure 17). This reflects the employer tax credit under their proposal, most of which would go to firms that already offer coverage. It also reflects the fact that some of those who become eligible and enroll in the Medicaid/S-CHIP expansion would be people who discontinue their employer coverage in favor of taking publicly subsidized coverage (that is, “crowd out”). In addition, it reflects cost-shift savings due to reduced uncompensated care expenditures for providers.

The three voluntary pool proposals (that is, Singer et al., Gruber, and Holahan et al.) would also result in savings to insuring employers by offering what in many cases would be a lower-cost coverage alternative. For example, the publicly sponsored insurance pool under the Gruber proposal would cover the Medicaid/S-CHIP population and people eligible for newly created premium subsidies. Average costs for these groups are \$203 and \$181 per person per month (PMPM) (Figure 18).

Employers can be expected to take coverage in the pool in cases where the public pool premium is less than what they are now paying for health insurance. This would include age-rated firms with older workers and experience-rated and/or self-funded health plans with high-cost enrollees. Consequently, the publicly sponsored insurance pool would experience a disproportionate accumulation of higher-cost cases (that is, adverse selection). Under the Gruber proposal, costs for the employer groups that shift to the publicly sponsored insurance pool would be \$261 PMPM, which would raise the premium in the public pool to \$243

PMPM (Figure 18).

These selection effects would result in a public subsidy for employers with higher-cost workers. For example, in the Gruber proposal, employers with costs of \$261 PMPM are able to cover their workers under the public pool by paying a premium of only \$243 PMPM. This results in an increase in public-sector health care costs because the average premium the government must pay to cover the Medicaid/S-CHIP and other low-income populations in the pool is \$243 PMPM, even though costs for this population are only between \$181 PMPM and \$203 PMPM. The amount the government pays for this population in excess of their actual costs is a subsidy to private employers who opt into the public pool.

While there are important differences among the three voluntary insurance pool proposals, they all result in a substantial amount of adverse selection into the public pools. This has the effect of providing public subsidies to employers with higher-cost workers who enroll in the public pools. Average savings per worker in currently insuring firms would be \$279 under Singer et al., \$673 under Gruber, and \$451 under Holahan et al. (Figure 17).

The two pay-or-play proposals would require employers that do not now offer insurance to contribute to the cost of covering their workers. Average costs per worker in firms that do not now offer coverage would be \$1,124 under the Hacker proposal and \$970 under the Weil proposal (Figure 17). Costs for currently insuring firms would actually decline by about \$409 per worker under the Hacker model, due largely to spousal equity provisions requiring employers to contribute to the cost of covering workers who take coverage as a dependent on a spouse’s employer plan.

The Kronick and Rice proposal would cost firms that do not now offer coverage about \$1,758 per worker, which is nearly twice the cost for these firms under the pay-or-play proposals. This is because, unlike under the pay-or-play model, employers must pay the payroll tax even if it is more than the cost of providing public coverage. Costs for employers that currently offer coverage would increase on average by about \$197 per worker. This is because the employer payroll tax rate under the proposal (7.0 percent) is greater than the average employer share of the

FIGURE 16: CHANGES IN EMPLOYER HEALTH SPENDING UNDER HEALTH REFORM PROPOSALS (BILLIONS)

	Currently Insuring Firm			Currently Non-Insuring Firm			All Firms					
	Premiums	Payroll Taxes	Premium Subsidy a/	Total	Premiums	Payroll Taxes	Premium Subsidy a/	Total	Premiums	Payroll Taxes	Premium Subsidy a/	Total
Current Law	\$284.3	—	—	\$284.3	—	—	—	—	\$284.3	—	—	\$284.3
CURRENT SPENDING												
CHANGES IN EMPLOYER HEALTH SPENDING												
Incremental Reforms												
Public Coverage Expansion with Employer Tax Credit: Feder, Levitt, O'Brien and Rowland	(\$10.1)	—	(\$4.7)	(\$14.8)	\$1.0	—	(\$0.7)	\$0.3	(\$9.1)	—	—	(\$14.5)
Adaptive Tax Credit Plan: Pauly	(\$2.5)	—	—	(\$2.5)	\$1.4	—	—	\$1.4	(\$1.1)	—	—	(\$1.1)
Voluntary Insurance Pool Proposals												
An Insurance Exchange Approach: Singer, Garber, and Enthoven	(\$23.7)	—	—	(\$23.7)	\$0.5	—	—	\$0.5	(\$23.2)	—	—	(\$23.2)
Private Public Partnership: Gruber	(\$28.7)	—	(\$48.3)	(\$77.0)	\$0.9	—	(\$0.6)	\$0.3	(\$27.8)	—	(\$48.9)	(\$76.7)
Federal/State Approach: Holahan, Nichols, and Blumberg	(\$38.2)	—	—	(\$38.2)	\$2.6	—	—	\$2.6	(\$35.6)	—	—	(\$35.6)
Pay-or-Play Models												
Medicare Plus: Hacker	(\$79.1)	44.5	—	(\$34.6)	\$2.4	\$30.7	—	\$33.1	(\$76.7)	\$75.2	—	(\$1.5)
The Medical Security System: Weil	(\$22.4)	22.2	—	(\$0.2)	\$9.4	\$19.4	—	\$28.8	(\$13.0)	\$41.6	—	\$28.6
Proposals to Replace Tax Exclusion with Tax Credits												
Tax Credits with Insurance Pool: Wicks, Meyer, and Slow-Carroll	\$5.5	—	—	\$5.5	—	—	—	—	\$5.5	—	—	\$5.5
Variable Tax Credits: Butler	(\$11.0)	20.2	—	\$9.2	—	—	—	—	(\$11.0)	\$20.2	—	\$9.2
Tax-Financed Health Care System												
A State-Based Approach: Kronick and Rice	(\$241.8)	258.5	—	\$16.7	—	\$51.8	—	\$51.8	(\$241.8)	\$310.3	—	\$68.5

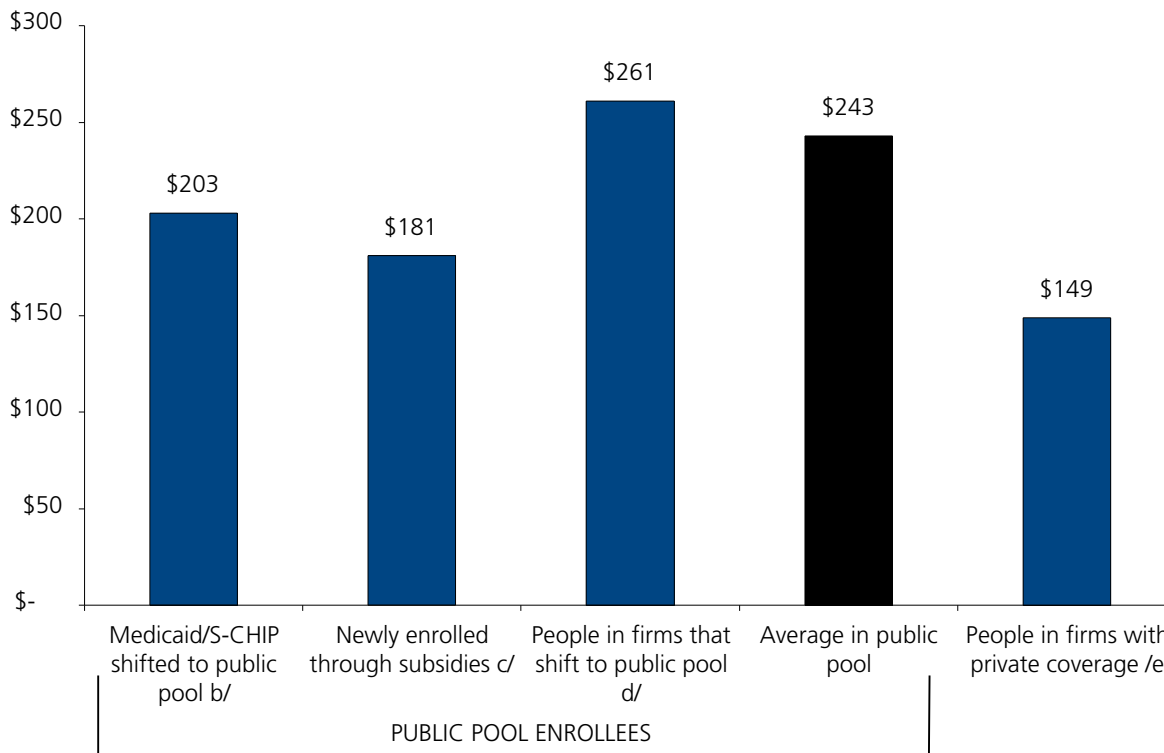
a/ Includes direct premium subsidies and tax credits. Premium subsidies are recorded as an offset to employer costs. Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

FIGURE 17: CHANGE IN EMPLOYER COSTS PER WORKER PER YEAR UNDER HEALTH REFORM PROPOSALS

	Currently Insuring Firm			Currently Non-Insuring Firm			All Firms		
	Premiums	Payroll Taxes	Total	Premiums	Payroll Taxes	Total	Premiums	Payroll Taxes	Total
Incremental Reforms									
Public Coverage Expansion with Employer Tax Credit: Feder, Levitt, O'Brien and Rowland	(\$120)	—	(\$175)	\$23	—	\$10	(\$80)	—	(\$48)
Adaptive Tax Credit Plan: Pauly	(\$30)	—	(\$30)	\$32	—	\$32	(\$22)	—	(\$22)
Voluntary Insurance Pool Proposals									
An Insurance Exchange Approach: Singer, Garber, and Enthoven	(\$279)	—	(\$279)	\$25	—	\$25	(\$202)	—	(\$202)
Private Public Partnership: Gruber	(\$251)	—	(\$251)	\$45	—	\$45	(\$172)	—	(\$172)
Federal/State Approach: Holahan, Nichols, and Blumberg	(\$451)	—	(\$451)	\$130	—	\$130	(\$304)	—	(\$304)
Pay-or-Play Models									
Medicare Plus: Hacker	(\$935)	\$526	(\$409)	\$82	\$1,042	\$1,124	(\$665)	\$652	(\$13)
The Medical Security System: Weil	(\$285)	\$263	(\$22)	\$317	\$653	\$970	(\$114)	\$365	\$251
Proposals to Replace Tax Exclusion with Tax Credits									
Tax Credits with Insurance Pool: Wicks, Meyer, and Silow-Carroll	\$65	—	\$65	—	—	—	\$48	—	\$48
Variable Tax Credits: Butler	(\$130)	\$239	\$109	—	—	—	(\$96)	\$177	\$81
Tax-Financed Health Care System									
A State-Based Approach: Kronick and Rice	(\$2,852)	\$3,049	\$197	—	\$1,758	\$1,758	(\$2,117)	\$2,717	\$600

Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

FIGURE 18: AVERAGE COST PER-MEMBER PER-MONTH (PMPM) FOR PEOPLE IN PUBLIC POOL UNDER THE GRUBER PROPOSAL IN 2002a/



a / Includes benefits costs, excluding program administration on a per-member per-month (PMPM) basis. Assumes a uniform benefits package based on Federal Employees Health Benefits Plan (FEHBP).

b/ Includes Medicaid and S-CHIP enrollees excluding Medicare recipients and disabled. Cost estimated using uniform FEHBP-style benefits package. Excludes the cost of wrap-around benefits for this population.

c/ Includes previously uninsured people and individuals currently with non-group coverage who enroll in the publicly sponsored insurance pool.

d/ Includes workers and dependents in firms that shift to the public pool because it is less costly than their current private coverage.

e/ Includes workers and dependents in firms that decide to continue with private coverage.

Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

cost of coverage per worker under their existing health plans.

Finally, we estimate that the two proposals to replace the employee health benefits tax exclusion with a refundable tax credit—that is, the Wicks et al. proposal and the Butler proposal—would both result on average in an increase in costs to employers that currently provide coverage. Under both proposals, many firms would experience savings as their workers shift to lower-cost plans in response to the change in the tax treatment of employer-sponsored health benefits. However, under the Wicks et al. proposal, many employers would see additional costs as they upgrade coverage to the minimum standard benefits package required under the proposal. Consequently, employers who now offer coverage would see on av-

erage a net increase in spending of about \$65 per worker.

Employer costs would also increase under the Butler proposal, even though the minimum benefits package under his proposal is a high-deductible plan (that is, \$1,000 deductible). The main reason for this is that, unlike Wicks et al., Butler eliminates the tax exclusion for Social Security taxes as well as the income tax exclusion (the Wicks et al. proposal eliminates only the income tax exclusion for employer benefits). Thus, the Butler plan requires workers and employers to pay Social Security and Medicare payroll taxes on the value of the health benefits they provide to the worker. The employer share of these payroll tax payments (that is, half) would be substantial, resulting in an overall average net increase

in employer costs of about \$109 per worker under the Butler proposal.

Household Sector Impacts

We estimated the impact of these health reform proposals on families, including changes in premiums, health spending, incomes, and taxes, as shown in Figure 19. We estimated the following effects for families:

- *Premium provision impacts:* Includes changes in family spending for health insurance premiums less premium subsidies and tax credits received.
- *Out-of-pocket spending:* Includes changes in direct payments by families for copayments and non-covered services.
- *Wage effects:* Wage changes (after taxes) resulting from changes in employee health benefits costs. Increases in wages are counted as an offset to family health spending, while wage losses are counted as an increase in family health spending.
- *Government financing:* This includes tax payments required to fully fund the program, including reductions in or elimination of the tax exclusion for employer health benefits.

Household health spending would be affected in several ways under these reform proposals. Although some of them would encourage enrollment in high-deductible health plans, the various proposals generally reduce family out-of-pocket expenses for health services by extending coverage to a large number of uninsured people. Family premium expenses also would be reduced for insured families that qualify for premium subsidies under these proposals. Also, some proposals would replace premiums with a payroll tax payment, such as the Kronick and Rice tax-financed proposal and the two pay-or-play proposals (public insurance pool enrollees only). In addition, some proposals would reduce or replace the tax exemption for employer-sponsored health benefits with a tax credit that would also affect the cost of coverage to families.

Changes in employer spending for health benefits under these proposals ultimately would be reflected in family wage income. Economic theory and evidence indicates that wage levels would adjust in the labor markets to reflect the change in employer health benefits costs under these proposals. Thus, in-

creases in employer health benefits costs are eventually passed on to workers in the form of reduced wage growth. For example, the increase in costs to firms that do not now offer insurance under the Hacker pay-or-play proposal (\$1,124 per worker, shown in Figure 17 above) would eventually result in a corresponding reduction in wage growth for affected workers. Conversely, the savings to firms that currently offer insurance under the Hacker proposal (\$409 per worker) would be passed on to workers as increased wage growth.

In this analysis, we count these changes in wages as changes in family health care costs. For example, reductions in wages resulting from increases in employer costs are counted as an increase in the cost of health care to the family. Similarly, increases in wages due to reductions in employer health benefits costs are treated as offsets to family health spending. The impact of these wage effects can be significant. The net change in family spending, including these wage effects, is shown in Figure 20.

These estimates should be treated with caution, however. Our analysis assumes that the changes in wages occur immediately upon employers' incurring changes in the cost of coverage. In fact, there is considerable debate among economists about how long it would take for these wage effects to materialize.

The estimated impact on households changes dramatically when we also account for the family tax payments that would be required to fully fund the program. All of these proposals would result in a net increase in federal spending, as shown in Figure 14 above. For illustrative purposes, we assumed that the unfunded federal cost of these proposals would be financed with a proportionate increase in federal personal income tax payments. When financing is included, families would see on average a net increase in health spending averaging between about \$178 per family under the Feder et al. proposal to \$668 per family under the Wicks et al. proposal (Figure 20). Thus, households would ultimately pay the full cost of any health reform proposal. For example, employer spending for health benefits is ultimately passed on to workers in the form of reduced wages and/or reductions in other fringe benefits. Under all of these proposals, increases in government spending are also passed on to households in the form of

higher taxes. Even corporate income taxes and federal deficit spending have been shown to ultimately affect households in the form of reduced investment

income and/or changes in consumer interest rates and product prices.

FIGURE 19: CHANGES IN HOUSEHOLD SPENDING FOR HEALTH CARE UNDER HEALTH REFORM PROPOSALS (BILLIONS)

	A	B	C	D	E	F	A+B-C+D+E+F
	Change in Premiums Net of Subsidies a/	Change in Out-of-Pocket	After-Tax Wage Gain/(Loss) b/	Taxes on Employer Health Benefits c/	Payroll Tax Payments	Federal Income Tax Payments	Net Impact on Households
Incremental Reforms							
Public Coverage Expansion with Employer Tax Credit: Feder, Levitt, O'Brien and Rowland	\$5.6	(\$8.1)	\$10.4	—	—	\$34.1	\$21.2
Adaptive Tax Credit Plan: Pauly	(\$47.4)	(\$7.4)	\$1.0	—	—	\$89.7	\$33.9
Voluntary Insurance Pool Proposals							
An Insurance Exchange Approach: Singer, Garber, and Enthoven	(\$28.4)	(\$19.5)	\$16.0	\$8.4	—	\$94.4	\$38.9
Private Public Partnership: Gruber	(\$39.8)	(\$12.5)	\$60.5	\$12.0	—	\$149.1	\$48.3
Federal/State Approach: Holahan, Nichols, and Blumberg	(\$41.6)	(\$14.1)	\$26.6	—	—	\$127.4	\$45.1
Pay-or-Play Models							
Medicare Plus: Hacker	(\$28.6)	(\$15.4)	\$1.3	\$1.6	—	\$87.5	\$43.8
The Medical Security System: Weil	(\$29.8)	(\$12.0)	(\$25.4)	—	\$19.4	\$58.9	\$61.9
Proposals to Replace Tax Exclusion with Tax Credits							
Tax Credits with Insurance Pool: Wicks, Meyer, and Silow-Carroll	(\$162.5)	(\$12.4)	(\$9.1)	\$91.0	—	\$154.4	\$79.6
Variable Tax Credits: Butler	(\$175.6)	(\$11.5)	(\$8.2)	\$118.7	—	\$105.1	\$44.9
Tax-Financed Health Care System							
A State-Based Approach: Kronick and Rice	(\$109.4)	(\$63.9)	(\$56.1)	—	\$129.5	\$46.6	\$58.9

a/ Includes changes in premiums under the proposal less premium subsidies and tax credits for premiums.

b/ Wage gains are treated as an offset (reduction) in household health spending while wage losses are treated as an increase in health spending.

c/ Includes reductions/elimination of employer health benefits tax exclusion.

Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

FIGURE 20: CHANGES IN AVERAGE ANNUAL HEALTH SPENDING PER FAMILY UNDER HEALTH REFORM PROPOSALS (DOLLARS)

	A	B	C	D	E	F	A+B-C+D+E+F
	Premiums a/	Out-of-Pocket	After-Tax Wage Gain/ (Loss) b/	Taxes on Employer Health Benefits c/	Payroll Tax	Federal Income Tax	Coverage, plus Wage Effect, plus Financing
CHANGES IN PER FAMILY SPENDING UNDER REFORM OPTIONS							
Incremental Reforms							
Public Coverage Expansion with Employer Tax Credit: Feder, Levitt, O'Brien and Rowland	\$47.0	(\$68)	\$87	—	—	\$286	\$178
Adaptive Tax Credit Plan: Pauly	(\$395)	(\$61)	\$8	—	—	\$746	\$282
Voluntary Insurance Pool Proposals							
An Insurance Exchange Approach: Singer, Garber, and Enthoven	(\$240)	(\$161)	\$134	\$73	—	\$788	\$326
Private Public Partnership: Gruber	(\$308)	(\$97)	\$468	\$93	—	\$1,154	\$374
Federal/State Approach: Holahan, Nichols, and Blumberg	(\$355)	(\$120)	\$226	—	—	\$1,085	\$384
Pay-or-Play Models							
Medicare Plus: Hacker	(\$240)	(\$129)	\$11	\$13	—	\$735	\$368
The Medical Security System: Weil	(\$258)	(\$104)	(\$220)	—	\$168	\$510	\$536
Proposals to Replace Tax Exclusion with Tax Credits							
Tax Credits with Insurance Pool: Wicks, Meyer, and Silow-Carroll	(\$1,360)	(\$108)	(\$77)	\$763	—	\$1,296	\$668
Variable Tax Credits: Butler	(\$1,478)	(\$97)	(\$69)	\$999	—	\$885	\$378
Tax-Financed Health Care System							
A State-Based Approach: Kronick and Rice	(\$858)	(\$501)	(\$440)	—	\$1,016	\$365	\$462

a/ Includes changes in premiums under the proposal less premium subsidies and tax credits for premiums.

b/ Wage gains are treated as an offset (reduction) in household health spending while wage losses are treated as an increase in health spending.

c/ Includes reductions/elimination of employer health benefits exclusion plus new taxes required.

The average family spending figures presented in Figure 20 mask a substantial shift in the distribution of income across socio-economic and demographic groups under these proposals. In general, our analysis showed that all of these proposals would reduce average health spending (that is, health spending with wage effects and financing) for families with less than \$50,000 in annual income, while increasing spending for people at higher income levels. This re-

flects the fact that all of these proposals would increase the proportion of health spending funded through payroll and income taxes, both of which are substantially more progressive than financing health care through premiums. Estimates of the change in family spending by income, age, and current insured status are presented in the detailed analyses for each of these proposals presented in appendices B through K. ■

Caveats

Many of the proposals considered in this study have never been attempted on a broad scale in the United States. Consequently, there are few data on the likely outcomes of such programs that can be used to estimate their impacts. In particular, programs that substantially restructure the health care financing system could fundamentally change consumer, employer, and provider incentives in ways that would have a significant impact on program costs.

For example, it is difficult to predict the states' willingness to implement optional expansions in Medicaid/S-CHIP coverage. It is also difficult to predict enrollment behavior among newly eligible groups such as non-custodial adults, many of whom are in substantially different economic and family circumstances from the currently eligible population. In addition, there is wide disagreement over the extent to which newly eligible people with employer-sponsored coverage would shift to public coverage.

There is also little evidence to guide us in estimating the impact of the various tax subsidy and premium subsidy programs considered in this study. We have attempted to estimate the number of eligible people who would be induced to take coverage due to these programs based on historical data on the relationship between the price of private insurance and the number of people with coverage. However, the methods used to provide health insurance subsidies could have a significant impact on coverage levels. For example, a health insurance tax credit administered through the tax code may have a very different impact on coverage from a premium voucher program that involves a separate application and income verification process.

Several of these proposals also include changes in tax incentives and/or managed competition models designed to create incentives for people to enroll in lower-cost and/or high-deductible health plans. Our estimates are based on extrapolations from data on the impact of price on the choice of health plans and estimates of the savings that can be realized through various types of managed care. However, it is unclear whether these assumptions adequately model the changes in coverage and spending that would result from the unique incentives created under the

proposals.

Another concern is estimating the impact of the automatic enrollment provisions introduced under these proposals. We have estimated the impact of automatic enrollment based on an analysis of the difference between enrollment rates in employer plans and the percentage of workers in non-insuring firms who purchase non-group coverage (adjusted for differences in demographic characteristics and the price of coverage). However, it is likely that workers have, to some degree, sorted themselves into jobs with health benefits based on their preferences for health coverage. This means that some of what we have attributed to automatic enrollment may actually be due to this sorting, so that we may have overestimated the impact of adopting automatic enrollment.

There are also issues with our simulation of default enrollment systems that would automatically cover people who do not have coverage. We have assumed that this would be successful for employed people who can be tracked through the employer income tax withholding system. However, we estimate that only about 70 percent of the non-worker population could be tracked through IRS records, which leaves several million people without insurance. We assume that nearly all of these people are picked up if the proposal includes substantial tax penalties for failing to maintain coverage. In fact, we have little empirical basis for these assumptions, which can have a large impact on our enrollment estimates.

Throughout this analysis, we have also assumed that the various subsidy schemes are administratively feasible, even though it is unclear how some of these programs would be implemented. For example, for a refundable tax credit program to be effective, there must be ways for individuals to obtain the tax credit at the time they are purchasing coverage rather than waiting until the following spring for their tax refund. Similarly, the government would need to develop the administrative structures required to administer a means-tested premium subsidy program. We assume that these administrative issues are resolved so that people who are induced by the subsidy to take the coverage can do so.

FIGURE 21: SENSITIVITY OF ESTIMATED COST AND COVERAGE IMPACTS OF THE REFORM PROPOSALS IN 2002

	Reduction in Uninsured (millions) a/			Net New Federal Costs (billions) b/		
	Low-Range Estimate	Best Estimate	High-Range Estimate	Low-Range Estimate	Best Estimate	High-Range Estimate
	Incremental Reforms					
Public Coverage Expansion with Employer Tax Credit: Feder, Levitt, O'Brien and Rowland	9.2	12.0	14.8	\$24.8	\$34.1	\$45.7
Adaptive Tax Credit Plan: Pauly	15.3	20.5	25.7	\$79.8	\$89.7	\$100.9
	Voluntary Insurance Pool Proposals					
An Insurance Exchange Approach: Singer, Garber, and Enthoven	8.9	11.8	14.7	\$80.0	\$102.8	\$132.1
Private Public Partnership: Gruber	10.8	14.5	18.0	\$145.1	\$190.5	\$250.0
Federal/State Approach: Holahan, Nichols, and Blumberg	11.4	15.2	19.0	\$97.1	\$127.4	\$167.2
	Pay-or-Play Models					
Medicare Plus: Hacker	34.1	37.0	39.9	\$224.7	\$241.9	\$260.4
The Medical Security System: Weil	34.0	36.9	39.8	\$146.7	\$160.9	\$176.5
	Proposals to Replace the Tax Exclusion with Tax Credits					
Tax Credits with Insurance Pool: Wicks, Meyer, and Silow-Carroll	40.3	40.3	40.3	\$219.3	\$230.8	\$242.3
Variable Tax Credits: Butler	20.2	26.9	33.6	\$217.2	\$236.1	\$256.6
	Tax-Financed Health Care System					
A State-Based Approach: Kronick and Rice	40.3	40.3	40.3	\$526.2	\$551.7	\$578.4

a/ We varied the enrollment rates by the amount of the standard error of estimate for the program participation regression equations that form the basis of our enrollment estimates. This results in an approximate variation in coverage rates of 25 percent on either side of the predicted value. Under the Hacker et al. and Weil proposals, we assumed full enrollment of workers and dependents with 25 percent variation in enrollment of non-workers. High-range enrollment of the uninsured was capped at 40.3 million (affects proposals by Wicks et al. and Kronick and Rice).

b/ In the low-range estimates, we assume the following: (1) low-range enrollment in public program (that is, 25 percent lower), and (2) per capita program costs are 5 percent lower than estimated. In the high-range scenario, we assume the following: (1) high-range enrollment in public program (that is, plus 25 percent), and (2) per capita program costs are 5 percent greater than estimated.

Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

To illustrate the potential sensitivity of our estimates to these assumptions, we estimated the number of uninsured who would become covered and net public program costs under each of the reform proposals using alternative participation and cost assumptions. We developed high-range and low-range estimates of enrollment by varying the participation rates for these programs by about 25 percent above and below our best estimate values.¹⁷ Figure 21 presents the resulting estimates of the number of uninsured people who would become covered. We also present our estimates of net program costs under these proposals at these high- and low-range enrollment levels assuming that per capita costs and revenues differ from our projections by 5 percent above and below our best estimates.¹⁸

Finally, all of the estimates presented above assume that these programs are fully implemented in 2002. In fact, our experience with S-CHIP and prior Medicaid eligibility expansions indicates that it would take up to two years before these programs are fully implemented. This reflects the time it takes to establish and implement new programs and lags between the time the program is introduced and

the point at which the public has become generally aware of their potential eligibility. Consequently, for budgetary purposes, we provide in the appendices (appendices B through K) 10-year estimates of the cost of these programs, which reflect these expected lags in enrollment, and the actual dates of implementation for these proposals.

Although we have tried to base our analyses on the best data and research now available, these estimates should be considered illustrative of potential program impacts rather than point estimates of actual program outcomes. In fact, our analysis indicates that the ultimate impact of these proposals on government health spending and coverage is very sensitive to assumptions about employer and consumer behavioral responses under the new incentives created by these programs.

Furthermore, the estimates are based on projections of health care costs, which are very sensitive to underlying health care trends. Consequently, policy makers should recognize that any major health initiative is likely to require continued refinements in program design and financing over time. ■

¹⁷ We varied the enrollment rates by the amount of the standard error of estimate for the program participation regression equations that form the basis of our enrollment estimates. This results in an approximate variation in coverage rates of 25 percent on either side of the predicted value. Under the Hacker and Weil proposals, we assumed full enrollment of workers and dependents with 25 percent variation in enrollment of non-workers. High-range enrollment of the uninsured was capped at 40.3 million (affects proposals by Wicks et al. and Kronick and Rice).

¹⁸ In the low-range estimates, we assume the following: (1) low-range enrollment in public program (that is, 25 percent lower), and (2) per capita program costs are 5 percent lower than estimated. In the high-range scenario, we assume the following: (1) high-range enrollment in public program (that is, plus 25 percent), and (2) per capita program costs are 5 percent greater than estimated.