# Covering America

## REAL REMEDIES FOR THE UNINSURED

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

John Sheils
Randall Haught

*Appendix K*

## A Plan for Achieving Universal Health Coverage: Combining the New with the Best of the Past

by Elliot K. Wicks, Jack A. Meyer, and Sharon Silow-Carroll

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# Elliot Wicks, Jack Meyer, and Sharon Silow-Carroll Plan

The authors propose to replace the existing income tax exclusion for employer-provided health benefits with a refundable tax credit. All individuals and families would receive the full amount of the credit regardless of how much of the premium was paid by an employer. However, all employer contributions for health benefits would be treated as taxable income to the employee.

All individuals are required to have insurance coverage that is at least as comprehensive as the Medicare benefits package plus prescription drugs and well-child care. Insurers would be required to offer a benefits package based upon the Medicare package and a Medicaid equivalent package in addition to other benefits packages that the insurer may offer. The program would also establish new insurance purchasing pools called Aggregate Purchasing Arrangements (APAs) to facilitate the purchase of coverage.

In this section we summarize the specifications of the authors' proposal and explain how we simulated the program's impacts. We also present our estimates of the impact of this proposal on coverage and costs.

## A. Program Specifications

### *1. Tax Subsidies*

The authors propose to provide a fully refundable tax credit to all individuals and families for the purchase of insurance. These credits would be determined as follows:

- The maximum tax credit for families above the national median family income would be equal to the current average value of the income tax exclusion for those who have employer-sponsored coverage (estimated to be $700/yr for individuals and $1,500/yr for families).[1]
- Families below the median income level would receive a larger, income-dependent tax credit as follows:
  - Families below the FPL would receive a maximum credit equal to the cost of purchasing coverage equivalent to the current Medicaid benefits package (discussed below). People below the FPL are expected to take the Medicaid package.
  - This maximum credit would be phased-out on a sliding scale with income for persons with incomes between the FPL and the median income level, where the credit would equal the amount described above (e.g., $700/yr. single $1,500/yr. family).
- The credit for those below the median income would be adjusted to reflect differences in regional medical costs so that the credit for those below the FPL would be

[1] Excludes the portion of the health benefits tax expenditure attributed to Social Security and Medicare taxes.

sufficient in every area to purchase coverage equivalent to the full Medicaid benefit package including all optional benefits. The credit for those above the median would not be adjusted for differences in regional medical costs.

- The size of the subsidy would depend on the previous year's income to allow for advance payments of credits. Eligibility and reconciliation would take place at tax time.
- Families experiencing a drop in income can apply to receive advance payments of the tax credit at other times.
- The subsidy amounts would be updated for cost growth over time as follows:
  - Increases in the amount of the subsidy to families above the median income would be at the discretion of Congress.
  - The subsidy amount provided to families below the FPL would be equal to the premium for a plan equivalent in value to the current Medicaid benefits package.
- The subsidy amount is the same regardless of the amount the employer contributes to the premium if any.

### *2. Benefits Packages*

The authors specify a minimum package of health benefits that all individuals must have.

- The minimum benefits package would be based upon the Medicare benefits package. It would include:
  - Medicare part A and B services;
  - Outpatient prescription drugs; and
  - Well-child care.
- Deductibles and co-payments for Medicare part A and B services would be the same as under the current Medicare program. A multi-tiered co-payment approach would be used for prescription drugs (i.e., generic, brand name etc.), averaging about $15 per prescription. The Medicare benefits package would have no limit on out-of-pocket spending as under the current program.
- Persons living below the FPL would be eligible for benefits equivalent to what is included in the current Medicaid benefits package. We assume that the Medicaid benefits package in all states would be equal to the most comprehensive package now offered by any state.

### *3. Individual Requirements*

- Health insurance coverage would be required for all individuals. Individuals would be required to provide documentation of coverage during the prior year with their tax return.

- Those not covered by private insurance would be automatically covered by the augmented Medicare plan with the benefits package described above.

- Those defaulting into the augmented Medicare coverage would pay a monthly premium for this coverage equal to the actuarial cost of coverage for those benefits, plus a 10 percent surcharge. These fees would be assessed retrospectively and would become part of the person's federal income tax liability, if a prior coverage lapse is discovered, regardless of whether claims were filed in the period.

### *4. Employer Requirements*

- All employers would be required to offer some health coverage to their employees. However, the employers are not required to contribute to the employees' cost of the plan.

- The coverage an employer offers can be of their own design, but must be at least as comprehensive as the augmented Medicare benefits package described above.

- This requirement can be fulfilled by offering coverage through insurance pools created under the proposal called "Advanced Purchasing Arrangements" (APA) in their state (described below).

- Employers with 10 or fewer employees must offer insurance only through the APA.

- Employers offering their own plans must allow those employees with income below the national median to opt out of the plan, and purchase insurance through the APA as an individual. Employers must make the same contribution to APA that they would have made if the individual were covered under the employer plan.

### *5. New Insurance Pools*

Each state would be obligated to create one or several new insurance pools, called Aggregate Purchasing Arrangements (APAs).

- Each insurer participating in an APA must offer as options (both in and out of the APA) the augmented Medicare benefits package and the Medicaid benefits package. Plans may offer other benefits packages as well.

- The states would choose the health plans to be offered in the APA. No health plan operating in the state could refuse to participate in the APA.

- Both within and outside the APA, insurers would be obligated to offer guaranteed eligibility to all individuals and groups of 100 or fewer, at community-rated premiums (adjusted for family size, but not age). The community rate would be based upon the insurer's business in each state both in and out of the APA.

- Groups of 100 or more are also guaranteed eligibility in the APA, but their rates may be group-rated (and thus they also fall outside the community-rating pool).

- Firms with fewer than 100 employees would be prohibited from self-funding to escape the community rate. (Many small firms are now self-insuring with reinsurance.)

- Premiums charged to APA participants can be no higher than those charged by the insurers to groups outside the APA for the same coverage.

### *6. Disposition of Medicaid*

- Medicaid and SCHIP would be almost entirely eliminated. Those previously covered under these programs would now be eligible for refundable tax credits to purchase insurance privately.

- Medicaid coverage would remain for the following:

  - Long-term care services including nursing home and home health;
  - Low-income Medicare recipients; and
  - School based therapeutic services under EPSDT would be continued.

- All Medicaid enrollees who currently qualify as disabled (excluding the Medicare dual-eligible population) and persons qualifying as medically needy under the spend-down provisions would obtain private insurance subject to whatever income-related subsidies for which they qualify.

- Under the proposal, states are responsible for all Medicaid long-term care and for necessary wrap-around services to the non-TANF population, who need care that is not medical in nature but is now provided under Medicaid. States would be responsible for maintaining their current effort up to the point needed to cover the costs of these services. If the costs exceed their current effort, the federal government would pick up the difference. If the state has money left over (which we assume would usually be the case), they get to keep it. There is no refund to the federal government.

### *7. Insurance Regulation*

- All insurance companies are required to guarantee issuance to all applicants in groups with fewer than 100 persons (including individuals), at community-rated premiums. Effectively, this means that all of the individuals and small groups, within a defined geographic region, are pooled together for each insurer.

- Non-Medicare persons who otherwise would have qualified for Medicaid as disabled or through the medically needy spend-down provisions would become part of this insurance pool. This would increase premiums in the individual/small group markets.

- Premiums for these individuals and groups can be adjusted only to reflect family size and composition, and regional medical cost differences.

#### *8. Financing*

- Employer-paid premiums for employer-provided health insurance would no longer be excludable from taxable income, resulting in increased income tax revenues for the federal government and in states where taxable income is based upon federal taxable income. (However, the employer-paid premiums are still exempt from the FICA tax under the authors' proposal.)

- The health benefits portion of Section 125 Flexible Spending Accounts is eliminated.

- The elimination of most of Medicaid and SCHIP would reduce spending for the federal government and the states.

- The states would be expected to assume a larger share of the cost of the continuing Medicaid coverage for long-term care. Initially, the states' share would be any costs up to the amount they currently spend on Medicaid. Ultimately, the states' share would be based on an ability to pay formula that is not yet specified.

- Those under 65 who don't buy private coverage and default into the augmented Medicare system, would be responsible for paying a premium-equivalent when their federal taxes are due to cover those benefits, plus a 10 percent surcharge.

### B. Key Assumptions

We estimated the impact of this proposal using the Lewin Group Health Benefits Simulation Model (HBSM), which is based upon data from the 1996 Medical Expenditures Panel Survey (MEPS), and the 2001 Current Population Survey (CPS). Workers in these data are also matched to individual firms in the 1999 Kaiser/HRET Annual Employer Health Benefits Survey to enable us to model the impact of firm-level decisions affecting worker coverage. The data and methods used are presented in ***Appendix A*** of this report.

Our key assumptions are summarized in the following sections:

- Community-rated premiums;

- Employer mandate;

- Participation by non-workers;

- Choice of health plans in community-rated pool;

- Benefits outside community-rated pool;

- Administrative costs; and

- Impact of tax credit on health spending.

### *1. Community-Rated Premiums*

The proposal would merge selected groups of individuals into a community-rated insurance pool. These include:

- All workers in firms with 10 or fewer workers are in the APA which is part of the pool;
- Persons currently covered under Medicaid (excluding the aged);
- Persons with incomes below the median income level who chose to take coverage through the APA; and
- Persons not associated with employment as a worker or dependent.

In addition, insurers are required to community rate premiums both within the APA and for firms with fewer than 100 workers outside the APA. This effectively makes all firms with fewer than 100 workers part of a single community-rated pool.

We estimated these community rates using the health expenditure data provided in the MEPS data - which form the basis of HBSM – for persons in these groups (***Figure 1***). We identify the individuals in these data who would be included in the pool. We then computed the amount of health expenditures that would be covered under the augmented Medicare and the Medicaid benefits packages using actual health spending data for these individuals. These data were then used to estimate premiums for this group. Under the proposal, premiums vary only by type of coverage (i.e., single, family etc.).

**Figure 1**
**Premium Amounts in Community-Rated Pool in 2002** [a/]

| Family Size | Medicaid Benefits Package for Persons Below Poverty | Standard Benefits Under Authors' Proposal |
|---|---|---|
| Individual | $312 | $245 |
| Couple | $625 | $490 |
| Two Parent | $805 | $612 |
| One Parent | $479 | $380 |
| **Per Person** | **$269** | **$207** |

a/ Estimated for persons in the APAs and firms with under 100 employees.
Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

As discussed above, firms with over 100 employees would be permitted to obtain coverage through the APAs. However, the APAs would be permitted to rate premiums for these firms separately to correct for any adverse selection that could occur. In this analysis, we assume that firms with 100 or more workers who enroll their workers in the APA would be rated separately from the community-rated pool described above.

### *2. Enrollment for Persons Below the Median Income Level*

As discussed above, persons with incomes below the median income level have the option of enrolling in the APA where the Medicaid benefits package is available. This includes persons with incomes below the median who have access to employer-sponsored coverage. In these instances, the employer is required to administer payroll withholding for eligible persons who request coverage through the APA.

The likelihood that eligible workers would take this option is difficult to predict under this proposal. This is because, under the plan, the worker receives the full amount of the credit that they are eligible to receive even if it exceeds the amount of the employee's premium contribution requirement. Thus, eligible persons could receive the difference between the credit amount and their premium contribution as cash that can be used as the recipient chooses. The only restriction is that the tax credit payment can not exceed the total premium (i.e., employee contribution plus employer contribution) for their health plan.

In this analysis, we assumed that eligible workers shift to the APA for more comprehensive coverage only if the amount of their credit exceeds the total premium for the employer plan (i.e., the maximum credit amount they could receive). This would typically occur among persons at or below the FPL who qualify for a credit large enough to purchase the Medicaid benefits package in the APA, which would cost more than most employer health plans. Thus, we are assuming that these workers would prefer to maximize the cash that they receive from the credit rather than using the credit to purchase more comprehensive coverage through the APA.

### *3. Employer Mandate*

Under the authors' proposal, employers are required to offer coverage that meets the minimum standard benefits package under the proposal (i.e., Medicare plus drugs and well-child care). However, employers are not required to contribute to the employees' cost of coverage. Employers can meet this obligation by either providing their own coverage or covering their workers under the APA. The employer would be responsible for payroll withholding for insurance.

**Non-Insuring Firms:** Firms that do not currently offer insurance would sponsor coverage as required under the proposal. We assume that the employer would not contribute to the cost of insurance. Under the proposal, firms with fewer than 100 workers would be covered in the community-rated pool, while firms with 100 or more workers would be covered under an employer-sponsored plan. Dependents would be covered through the worker.

**Insuring Firms:** Currently offering firms with fewer than 10 workers would be required to obtain coverage through the community-rated pool, while firms with between 10 and 100 workers need not enroll in an APA. The dollar amount of the employer's premium contribution is assumed to be the same as under current law. Workers are assumed to pay

the remainder of the premium themselves, which would vary depending upon the type of plan selected by the worker (discussed below). Dependents would be covered under the worker's plan.

Insuring firms with 100 or more workers are assumed to continue to provide coverage. However, we assume that all workers with incomes below the median would enroll in the community-rated pool so that they can receive their subsidy (i.e., as long as the employee premium in the public pool less the premium subsidy is lower than what they would pay if in a privately rated pool). As described in the proposal, we assume that firms with 100 or more workers are rated separately for the community-rated pool to guard against adverse selection.

Employers would maintain their current contribution levels despite the fact that these contribution amounts would now be subject to federal income tax. This is because these contributions would continue to be excluded from FICA payroll taxes. Thus, some of the tax advantages of employer-provided insurance would remain.

We assume that all persons in insuring firms who are eligible for but are not enrolled in employer coverage would now obtain coverage in the public pool if they are below the median income level or under the employer plan if they are not. The employer premium contribution amount is assumed to be the same as they now pay for plan participants.

In addition, workers who are currently ineligible for coverage under their employer's plan would become covered by the employer. However, we assume that the employer would provide only the minimum standard of benefits for these persons and the employer would make no contribution towards the cost of this coverage.

### *4. Participation by Non-Workers*

We adopted rules to simulate coverage of non-workers under the proposal. Non-workers include persons who are not in the labor force as well as persons without coverage for parts of the year as they move from one job to another. These coverage rules apply to all non-workers during the portions of the year in which they are not working.

As discussed above, we assume that all workers obtain coverage under the proposal. This is because these persons must file tax returns, which can be used to facilitate an enrollment mandate. However, coverage for non-workers is enforceable by the IRS only for those non-workers who must file a tax return (e.g., retirees, investment income etc.). Consequently, we adopted the following assumptions for non-workers who do not have enough income to file a tax return:

- Persons enrolled in the current Medicaid and SCHIP programs are assumed to enroll;
- Non-workers who are eligible for but not enrolled in the existing Medicaid/SCHIP program would not obtain coverage, except to the extent that they have employer coverage;

- Other non-workers would elect to enroll in the program based upon participation rates under the existing Medicaid program. These participation rates result in enrollment of about 70 percent for eligible persons who otherwise would be uninsured.

It is important to note that anyone who is not insured would automatically be enrolled in the augmented Medicare program when they access a health provider.

### *5. Choice of Health Benefits Plans*

One of the primary effects of the proposal would be a change in the incentives for purchasing coverage. The elimination of the personal income tax exclusion for employer health benefits would reduce incentives to choose more comprehensive benefits packages to maximize tax benefits. Employees would often prefer getting additional compensation in the form increased money wages rather than richer health benefits because there would no longer be any tax benefit to taking the additional compensation as health benefits. These changes in the tax treatment of employer contributions for health benefits would create incentives for people to enroll in less costly health plans.

Consumers could respond to the change in the tax exemption by shifting to more restrictive managed care plans and/or by moving to a less comprehensive policy such as the minimum benefits package under this proposal. We assumed the following for the poor and newly insured:

**Persons qualifying for full subsidies:** All persons with incomes below the FPL are assumed to take the Medicaid benefits package.

**Previously uninsured persons:** Newly insured persons with incomes between the FPL and the median income level are assumed to take the greater of the augmented Medicare benefits package and the most comprehensive coverage available for the amount of their subsidy. If the minimum benefits package is not available for the amount of the subsidy, the individual must pay the difference. All newly insured persons who qualify for only the minimum subsidy are assumed to take the minimum standard benefits package. We simulated this wide variation in coverage by phasing-in the Medicare co-payment amounts in proportion to the difference between the coverage level chosen by the individual and the augmented Medicare benefits package.[2]

We also assume that utilization of health services by previously uninsured persons would increase to the levels reported by insured persons with similar characteristics (i.e., adjusted for the impact of high-deductible plans).[3]

[2] For example, a person choosing a benefits plan with an actuarial value halfway between the Medicaid package and the Medicare package would have cost sharing parameters that reduce cost sharing by roughly half of what they are under the Medicare package.

[3] "The Financial Impact of the *Health Security Act*," The Lewin Group Inc., December, 1993.

**Currently insured persons:** We assume that the program's primary effect on this population would be to shift individuals from fee-for-service (FFS) plans (including PPO or POS plans) to HMOs, and/or to move people to the minimum benefits package. Our approach was to simulate the shift to these types of plans based upon the change in out-of-pocket premium payments under the proposal and published price elasticity estimates for demand for health coverage. Premiums were defined as follows:

- **Current policy premiums:** For persons with employer coverage, the premium under current policy was defined as the employee premium contribution amount. For persons with non-group coverage, the out-of-pocket premium includes the full amount of the premium paid for their policy.

- **Premiums under proposal:** Premiums for persons with employer coverage under the policy are equal to: the employee contribution amount; plus, the increase in taxes due to eliminating the tax exclusion (FICA tax exemption is retained); less, the amount of the tax credit under the proposal. For persons with non-group coverage, the premium is equal to the premium they pay less the amount of the credit.

We estimate the number of persons who would drop their current coverage to enroll in a less costly plan based upon the change in the cost of remaining in their current plan and our price elasticity assumptions. Based upon the available research, we assume that the price elasticity for coverage in multiple choice offerings (i.e., offered a choice of coverage options) varies with age and health risk, averaging -2.47.[4] These data generally show that older and sicker consumers are less price sensitive than younger and healthier individuals.[5] Individuals were randomly selected to shift to a lower cost plan based upon these estimated price changes and these price elasticity assumptions.[6]

Once individuals are selected to change their source of coverage, we assume that some would shift to HMOs while others would move to the minimum benefits package. We assumed that all persons in HMOs under current law who are chosen to change their source of coverage shift to the minimum benefits package under the proposal. Persons in FFS plans who are selected to change coverage are assumed to enroll in HMOs. Changes in spending were estimated as follows:

**HMO enrollees:** Based upon available research, we assume that HMOs are about 12.0 percent less costly than fee-for-service plans.[7] Thus, we reduced spending or all persons assigned to an HMO by 12 percent. In addition, we assumed that the rate of growth in health spending is reduced as the percentage of persons enrolled in HMOs increases. For example, studies indicate that a 10 percent increase in the number of persons enrolled in

[4] Strombom, Bruce A., Buchmueller, Thomas C., Feldstein, Paul J., "Switching Costs, Price Sensitivity and Health Plan Choice", Journal of Health Economics, October 2001.
[5] The elasticity ranges from -3.5 for persons under the age of 31 who are at a low risk for health expenditures to -1.38 for high-risk individuals over the age of 45.
[6] Newly insured persons were randomly assigned to HMOs based upon the percentage of privately insured persons who are in HMOs after we have executed our simulation for currently insured persons.
[7] "New Evidence on Savings from Network Models of Managed Care," (report to the Healthcare Leadership Council), The Lewin Group, May 1994.

plans with selective contracting is associated with a reduction in the annual rate of growth in hospital spending of up to 1.5 percent.[8] Based upon a review of these studies, we assume that each 10 percent increase in the number of persons enrolled in HMOs would result in a reduction in spending growth of 1.3 percent for hospital services and 0.6 percent for physicians' services. We used this assumption to simulate the impact of the program on the long-term rate of growth in health care costs.

**Minimum standard plan enrollees:** We assume that workers and dependents who shift to the minimum standard plan would reduce their utilization of health services. After a review of the available literature, we assume that the use of health services will decline by 0.2 percent for every one-percent increase in out-of-pocket costs for services.[9] The change in cost sharing was based upon a comparison of total out-of-pocket health spending for the affected population under current policy and under the minimum benefits package.

Based on these assumptions, we estimated about 28.2 million persons would change plans under the authors' proposal (***Figure 2***).

**Figure 2**
**Number of Persons who Change Type of Health Plan under the Authors' Proposal in 2002**

| | Privately Insured Persons under Current Law (millions) | Number of Persons who Change Plans (millions) |
|---|---|---|
| Number of Persons Currently in HMO Plans | 44.2 | 8.0 (Assumed to Enroll in Minimum Benefits Plan) |
| Number of Persons Currently in FFS plans | 138.2 | 20.2 (Assumed to Enroll in HMO) |
| **All Persons Currently with Privately Insurance** | **182.4** | **28.2** |

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

### *6. Administrative Costs*

There are three types of administrative costs that were estimated for this program:

- Insurer administrative costs;
- APA administrative costs; and
- Administration of tax credits.

[8] Robinson, J.C., "HMO Market Penetration and Hospital Cost Inflation in California," *Journal of the American Medical Association*, 266 (20 November 1991): 2719-23.
[9] W. G. Manning, J. P. Newhouse, N. Duan, E. B. Keeler, A. Leibowitz, and M. S. Marquis. "Health Insurance and the Demand for Medical Care: Evidence from a Randomized Experiment," *The American Economic Review*, Vol. 77, No. 3, June 1987, pp. 251-277.

**Insurer administration:** Administrative costs in health plans are assumed to be about 19 percent of benefits costs for the self-employed and non-group enrollees. This rate of administration is based upon the administrative overhead rates experienced in large non-group plans. We assume that administrative costs for employer groups, which vary from as high as 40 percent in small firms to 3.5 percent in the largest firms, would be the same as in existing employer health plans, up to a maximum of 19 percent. This reflects the fact that small groups would continue to be more costly to administer than larger firms, even in the APA. Because all employers are required to facilitate coverage for their workers, these assumptions apply to workers in all firms, including those who do not sponsor coverage.

We also assumed that administrative costs for Medicaid recipients who are shifted to private coverage through the public plan would be equal to 19 percent of covered claims. However, we assumed that this increase in administrative costs occurs only among the portion of Medicaid beneficiaries who are not already enrolled in private managed care plans.

**APA administrative costs:** These include the cost of processing enrollment in the various plans, arranging for premiums collections where necessary, and making payments to health plans. Many of these functions are currently performed by insurers and are accounted for in the insurer administrative costs estimated as described above. In this analysis, we allocated the portion of insurer administrative costs estimated above for functions that would be performed by the exchanges.

We assumed that the cost of administering the pool would be equal to about 4.5 percent of covered claims. This is based upon the cost of administration under the California Pac Advantage Program, which provides a selection of health plans for small employers in California (also includes the cost of a risk adjustment mechanism to correct for risk selection).

**Administration of tax credits:** The authors' proposal would replace the current exemption for employer-provided health benefits with a refundable tax credit for all individuals. However, many of the individuals who are eligible for the tax credit do not have enough income to pay taxes and often have a low attachment to employment. Consequently, we assume that much of the lower-income population would not be able to make effective use of the income tax and employer withholding system.

Consequently, we assume that a process will be needed to certify eligibility and arrange for payment of the tax credits under this proposal for all persons with incomes below the FPL and persons who qualify for the current Medicaid/SCHIP program. For these people, we assume the following:

- The cost of administering subsidies to individuals who are not employed would be equal $190 per family as under the Medicaid/SCHIP program.

- For persons who have employer coverage, the public cost of administering the subsidy is assumed to be about half that amount. This reflects the fact that under this proposal, all employers are required to facilitate enrollment and coverage for their workers.

In addition, we assume that the administrative budget for the Internal Revenue Service (IRS) (i.e., $9.9 billion) would be increased by 25 percent to administer these tax credits.

## C. Cost and Coverage Impacts

We present our estimates in two ways. First, we present estimates of the cost and coverage impacts of each provision of these proposals assuming full implementation in 2002. These estimates are useful for comparing program impacts at the current levels of the uninsured and health care costs. However, we expect enrollment to lag for up to two years as individuals learn about the program and begin to apply for these subsidies. Consequently, for budgetary purposes, we also present year-by-year cost estimates for 2003 through 2012, which reflect these expected lags in enrollment.

These results are presented in the following sections:

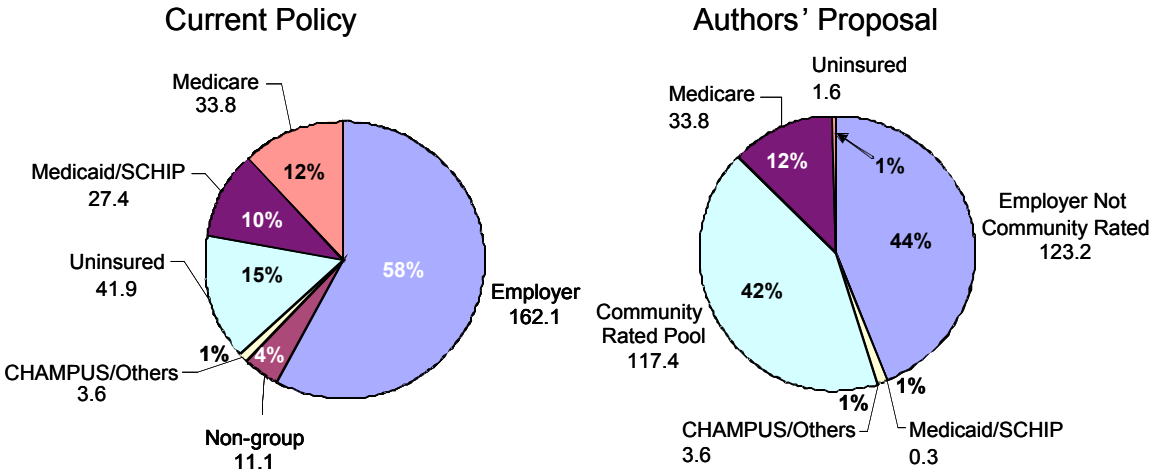
- Sources of coverage;
- Impact on national health expenditures;
- Program spending;
- Federal expenditures;
- Impact on state and local governments;
- Employer impacts;
- Impacts on households; and
- Expenditures in future years.

### *1. Sources of Coverage*

The plan would reduce the number of uninsured by about 40.3 million persons (***Figure 3***). This is a reduction of about 96 percent from our estimate of 41.9 million uninsured persons (average monthly count) in 2002.[10] Those who remain uninsured (1.6 million persons) would be non-workers or workers during periods of non-employment who decide not to seek benefits under the program. These persons are, however, automatically covered under the augmented Medicare program when they access the health care system.

[10] All population counts in this analysis represent average monthly enrollment by coverage source.

**Figure 3**
**Distribution of Persons by Primary Source of Coverage under Current Policy and the Authors' Proposal in 2002[a/]**
**(in millions)**




**Total Population = 279.9 million persons**

a/ Coverage presented on an average monthly basis.
Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

The authors' proposal would change the source of insurance coverage for many non-elderly Americans. Based upon our simulation of employer and consumer decision making described earlier, we estimate that there would be about 117.4 million persons enrolled in the community-rated pool (***Figure 3***). These include:

- Medicaid and SCHIP enrollees shifted to the APAs;
- Workers and dependents in firms with fewer than 10 employees in APAs;
- Workers and dependents in families below the median income level who find it advantageous to purchase coverage through the APAs;
- Persons with non-group coverage who enroll in the APAs;
- Currently uninsured persons not associated with employment who obtain coverage through the APAs under the program; and
- Workers and dependents in firms with 10 to 100 employees who are included in the community-rated pool regardless of whether enrolled in the APA.

***Figure 4*** summarizes the transitions in sources of coverage under the authors' plan.

## Figure 4
## Coverage Transitions Under the Authors' Proposal
## (in millions)

| Base Case Coverage | | Primary Sources of Coverage Under Proposal | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Community-Rated Pool | | | Other Private Coverage | | Other Sources | | | |
| | Total | Employer in APA | Individual in APA | Employer-Non APA | Employer | Non-group | CHAMPUS | Medicare | Medicaid | Uninsured |
| **Employer** | 162.1 | 36.1 | 0 | 16.6 | 109.4 | 0 | 0 | 0 | 0 | 0 |
| **Non-Group** | 11.1 | 4.0 | 3.3 | 1.0 | 2.8 | 0 | 0 | 0 | 0 | 0 |
| **CHAMPUS** | 3.6 | 0 | 0 | - | 0 | 0 | 3.6 | 0 | 0 | 0 |
| **Medicare** | 33.8 | 0 | 0 | - | 0 | 0 | 0 | 33.8 | 0 | 0 |
| **Medicaid** | 27.4 | 4.1 | 20.5 | 1.2 | 1.3 | 0 | 0 | 0 | 0.3 | 0 |
| **Uninsured** | 41.9 | 16.5 | 9.8 | 4.3 | 9.7 | 0 | 0 | 0 | 0 | 1.6 |
| **Total** | **279.9** | **60.7** | **33.6** | **23.1** | **123.2** | **0** | **3.6** | **33.8** | **0.3** | **1.6** |

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

Of the 117.4 million persons in the community-rated pool, 94.3 million would be persons enrolled in an APA. The remaining 23.1 million would be in firms with 10 to 100 workers who are required to be in the community-rated pool but decide to remain outside of the APAs.

About 123.2 million workers and dependents would be covered under private employer plans that are not included in the community-rated pool.[11] Private non-group coverage (currently 11.1 million persons) would be virtually eliminated as these individuals become covered through employment or enroll in the APAs.

The number of persons with Medicaid/SCHIP as their primary source of coverage (i.e., excludes Medicare dual eligible enrollees) would decline from about 27.4 million to 0.3 million persons. Those who continue to have Medicaid as their primary source of insurance would be a small number of aged persons who do not qualify for Medicare.

### *2. Impact on National Health Expenditures*

Health expenditures in the United States are projected to reach about $1.5 trillion in 2002. We estimate that national health spending would increase by about $52.1 billion under the authors' proposal (***Figure 5***). Payments for health services would increase by about $40.6 billion due to increased access to health services for newly insured persons and various effects of the program on utilization and provider reimbursement. Administrative costs would increase by about $11.5 billion, which includes the insurer administrative costs for newly insured persons and the government's cost of administering the tax credit.

**Figure 5**
**Changes in National Health Spending Under the Authors' Proposal in 2002**
**(in billions)**

| | | |
|---|---|---|
| **Change in Health Services Expenditures** | | **$40.6** |
| Change in utilization for newly insured | $26.2 | |
| Change in utilization due to improved coverage | $8.6 | |
| Shift to lower cost plans | ($8.5) | |
| Reimbursement effects | $17.2 | |
| Changes in provider reimbursement for Medicaid recipients $14.0 | | |
| Payments for uncompensated care $14.7 | | |
| Reduced cost shifting ($11.5) | | |
| Reduction in Medicaid DSH payments | ($2.9) | |
| **Change in Administrative Costs** | | **$11.5** |
| Insurer administration for newly insured persons | $5.1 | |
| Administration of tax credits | $6.4 | |
| **Total Change in Health Spending** | | **$52.1** |

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

[11] Some of these individuals would take coverage under the APA but would be rated separately from the community-rated pool to guard against adverse selection.

The increase in payments to providers for health services ($40.6 billion) includes the cost of increased health services utilization and changes in reimbursement rates under the program. Utilization of health services among newly insured persons and persons with improved coverage would increase by about $31.7 billion. This includes: $26.2 billion in increased spending for newly insured persons and about $8.6 billion increase in spending for persons who would become covered under a more comprehensive benefits package. This would be partly offset by an $8.5 billion reduction in spending for persons who shift to less costly plans. There is also a reduction in federal Disproportionate Share Hospital (DSH) payments of about $2.9 billion (DSH payments would be reduced in proportion to the reduction in bad debt and charity care expenses.)

Spending would increase by an additional $17.2 billion due to changes in provider reimbursement. Provider payment rates for services would increase by about $14.0 billion due to increases in reimbursement for services provided to Medicaid recipients who are shifted to the APAs (Private payment rates typically exceed Medicaid rates by about 20 percent). In addition, a portion of the care that is now provided as uncompensated care would become reimbursable due to the insurance expansion, resulting in an additional increase in provider income of about $14.7 billion. Higher provider payment rates would reduce cost shifting. We assume that about 40 percent of these changes in reimbursement would be passed on as savings to private health plans in the form of reduced cost-shifting ($11.5 billion), resulting in a total net increase in provider revenues of $17.2 billion.

As discussed above, administrative costs would increase by about $11.5 billion. Insurer administrative costs would increase by about $5.1 billion, which includes the cost of administering the APAs as described above, as large numbers of uninsured persons are shifted to the APAs. The administration of the tax credits would increase costs by an additional $6.4 billion resulting in an overall increase in administrative costs of $11.5 billion.

***Figure 6*** summarizes how these changes in spending are distributed over major stakeholder groups. Initially, federal spending on health care would increase by about $153.6 billion due to the tax credits. This is net of the elimination of the tax exclusion and other offsets. Spending for employers would increase by about $5.5 billion, reflecting

**Figure 6**
**Change in Health Spending by Stakeholder Group in 2002**
**(in billions)**

| | Without Wage Effects | With Wage Effects | With Wage Effects and Fully Financed |
|---|---|---|---|
| **Federal Government** | $153.6 | $154.4 | -- |
| **State and Local Government** | ($22.9) | ($27.5) | ($27.5) |
| **Private Employers** | $5.5 | -- | -- |
| **Households** | ($84.1) | ($74.8) | $79.6 |
| **Total Health Spending** | **$52.1** | **$52.1** | **$52.1** |

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

the fact that firms would now be covering workers who previously declined coverage or were excluded from their employer's plan. Economic theory and evidence indicates that wages would adjust (i.e., decline) over time to reflect the increase in employer health benefits expenditures.

State and local governments would see savings of about $27.5 billion due to reduced reliance on safety-net programs such as public hospitals and clinics. This also reflects changes in spending for state and local worker health benefits under the program.

Households would initially see savings of about $84.1 billion (before wage effects). However, these savings would be more than offset by wage effects and an increase in the personal income tax to cover the federal cost of the program. Thus, households would actually pay all of the cost of the increase in national health spending. Households ultimately would pay the cost of any health system reform, either directly when using medical services, through taxes, wage reductions or in the costs of goods and services they consume. The impact on various stakeholder groups is presented in greater detail in ***Figure 6***.

### *3. Program Spending*

Total program spending would be $314.4 billion if fully implemented in 2002 (***Figure 7***). Program spending would include about $308.0 billion in tax credits and about $6.4 billion in administering the tax credits. The premiums collected would fully fund the benefits costs and administration of the APAs.

These estimates reflect the fact that the current Medicaid and SCHIP coverage for the non-Medicare population would be folded into the APAs.[12] However, the Medicaid program would be retained with its current level of benefits for Medicare dual eligible beneficiaries.

Under the proposal, states would take full responsibility for long-term care benefits and would continue to cover certain wrap-around services. However, the increase in costs to each state is capped so that total state spending does not exceed current spending. This would result in savings to states where spending for long-term care and the wrap around services is greater than what they save from folding Medicaid for the non-Medicare population into the premium subsidy program. In addition, federal DSH payments are assumed to be reduced in proportion to the reduction in uncompensated care. Total spending for continued Medicaid services would be $141.7 billion in 2002.

The combined cost of the newly created public plan and the continued portions of Medicaid would be $456.1 billion if fully implemented in 2002. The federal matching rates for the portion of the Medicaid programs that are retained would be the same as under the current Medicaid program. Of the $456.1 billion in spending under these programs, the federal government would pay $362.2 billion with the states paying the remainder of $93.8 billion.

[12] Spending for the acute care population would be about $66.9 billion in 2002, including benefits and administration.

**Figure 7**
**Expenditures under Public Plans and Continued Medicaid Programs**
**(in billions)**

| | | Total | Federal | State |
|---|---|---|---|---|
| **APA Program Costs** | | | | |
| Tax Credits: | | | | |
| Tax Credits to Families | $308.0 | $314.4 | $314.4 | $0.0 |
| Administration of Tax Credits | $6.4 | | | |
| Community-Rated Pool: | | $0.0 | $0.0 | $0.0 |
| Benefits | $251.9 | | | |
| Insurer Administration | $37.4 | | | |
| APA Administration | $10.0 | | | |
| Premium Revenues (counted as an offset) | ($299.3) | | | |
| **Subtotal Program Costs** | | **$314.4** | **$314.4** | **$0.0** |
| **Continued Medicaid Program** | | | | |
| Aged and Disabled | | $46.2 | $25.7 | $20.5 |
| Long-term Care[a/] | | $56.1 | $0.0 | $56.1 |
| DSH (Federal only) | | $5.9 | $5.9 | $0.0 |
| Wrap-Around Coverage[a/] | | $9.8 | $2.9 | $6.9 |
| Other | | $10.0 | $5.6 | $4.4 |
| Administration | | $13.7 | $7.7 | $6.0 |
| **Subtotal Continued Medicaid Program** | | **$141.7** | **$47.8** | **$93.9** |
| **Total Program Costs** | | | | |
| **Total Program Costs** | | **$456.1** | **$362.2** | **$93.9** |

a/ The states become responsible for all long-tern care and wrap-around benefits up to a cap on the increase in state spending for these services equal to the amount of savings resulting from shifting the non-Medicare population into the premium subsidy program (estimated to be $36.0 billion).
Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

### *4. Federal Expenditures*

Total federal spending under the program would be $362.2 billion if fully implemented in 2002. This includes the federal share of all tax credits provided to families and the federal cost of the portions of Medicaid that would continue under the proposal (***Figure 8***).

**Figure 8**
**Changes in the Federal Spending Under the Authors' Proposal**
**(in billions)**

| | | Change in Spending |
|---|---|---|
| Federal Share of Spending under Program | | $362.2 |
| Tax Credits & Administration | $314.4 | |
| Continued Medicaid | $47.8 | |
| **Offsets** | | |
| Current Medicaid Funding (Federal) | | $131.9 |
| Elimination of Tax Exclusion | | $76.4 |
| Other Program Offsets | | $0.3 |
| Revenues Due to Wage Effects | | ($0.8) |
| **Total Offsets** | | **$207.8** |
| **Net Cost to Federal Government** | | |
| **Amount Raised through Income Tax Increase** | | **$154.4** |

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

The program would be partly financed with the $131.9 billion in funds that would have been used for the Medicaid and SCHIP programs in 2002. There would also be a savings of about $76.4 billion as the income tax exclusion for employer-provided health insurance is replaced with the tax credit program (the FICA tax exemption is retained under the authors' proposal). The federal government would also see a reduction in federal income and payroll tax revenues of about $0.8 billion due to the reduction in wages resulting from increased employer health benefits costs under the proposal.

Total revenues and offsets from all sources would be $207.8 billion, leaving about $154.4 billion to be raised through other means. We assume that these funds are raised through an increase in the personal income tax.

### *5. Impact on State and Local Governments*

As shown in ***Figure 7*** above, the state share of costs under the program would be $93.9 billion. This includes the state share of the cost of the portions of Medicaid, including the increase in state responsibility for covering long-term care and wrap-around benefits. State and local governments would see savings of about $10.1 billion in other safety-net programs for the medically indigent as the number of uninsured is reduced (***Figure 9***). There also would be a savings of about $14.6 billion for states with income taxes as the income tax exclusion for employer-provided health insurance is replaced with the tax credit program.

**Figure 9**
**Change in Health Spending for State and Local Governments Under the Authors' Plan**
**(billions)**

| | Change in Spending |
|---|---|
| State Share of Program Spending | $93.9 |
| **Offsets** | |
| Current Medicaid Funding | $95.8 |
| Savings to Other Safety-net Programs | $10.1 |
| Elimination of Tax Exclusion | $14.6 |
| State and Local Workers Health Benefits Savings/(Increases)<br>Savings for Workers and Dependents ($4.4)<br>Savings for Retirees 0.6<br>Wage Effect Offsets $4.4 | $0.6 |
| Change in Tax Revenue from Wage Effect | $0.3 |
| **Total Offsets** | **$121.4** |
| **Net Cost to State and Local Governments** | |
| **Net Savings** | **$27.5** |

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

State and local governments would incur additional costs as they are required to cover government employees who currently decline coverage. We estimate that total health

benefits costs for state and local government workers and dependents would increase by about $4.4 billion under the proposal. This would be partly offset by savings for retiree benefits of about $0.6 billion. However, as discussed above, we assume that increases in employer costs for workers and dependents (except retiree benefit savings) are eventually passed-on to workers in the form of lower wages, with little net impact on state spending. Thus the net effect of the program would be to reduce costs for state and local worker health benefits programs by about $0.6 billion.

In addition, state and local governments with income taxes would see a slight increase in tax revenues resulting from the wage effect for affected workers. Total net savings to state and local governments including revenue offsets would be about $27.5 billion.

### *6. Private Employer Impacts*

We estimate that private employers will spend about $284.3 billion on health benefits in 2002 ***(Figure 10).*** This includes total benefits and insurer administrative costs less employee premium contributions. Private employer spending (i.e., $284.3) includes about $264.7 billion in spending for workers and dependents and $19.5 billion in retiree benefits.

**Figure 10**
**Changes in Private Employer Health Benefits Costs by Current Insuring Status in 2002**
**(in billions)**

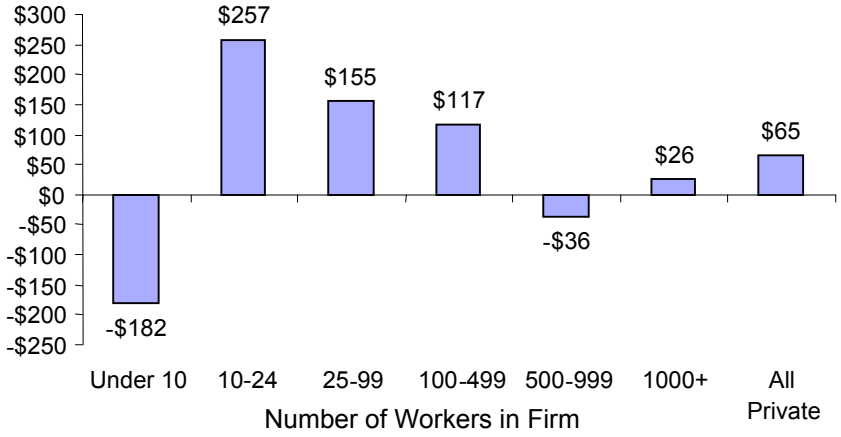
| | Insuring | Non-insuring | Total |
|---|---|---|---|
| **Private Employer Spending Under Current Policy** | | | |
| Current | | | |
| Workers & Dependents | $264.7 | -- | $264.7 |
| Retirees | $19.5 | -- | $19.5 |
| Total | $284.3 | -- | $284.3 |
| **Changes in Employer Health Spending Under the Policy** | | | |
| Cost of Covering Workers Who Currently Decline Coverage | $7.3 | -- | $7.3 |
| Cost of Benefits Upgrade | $7.3 | -- | $7.3 |
| Shift to Lower Cost Plans | ($3.9) | -- | ($3.9) |
| Cost Shift Savings [a/] | ($5.2) | | ($5.2) |
| **Net Change** | **$5.5** | **--** | **$5.5** |

a/ Includes only the employer share of the reduction in the cost-shift for private employer health plans. Excludes cost shift savings to workers in private health plans of $1.3 billion, cost-shift savings for government worker health benefits plans (employer and employee share) of $4.5 billion and saving to people with non-group coverage of $0.5 billion.
Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

We estimate that health spending among firms that currently provide coverage would increase by about $5.5 billion under the program. This includes the additional cost of covering workers who currently decline employer coverage (7.3 billion) and the cost of upgrading benefits to the minimum benefits standard. These increases in costs are partly offset by a shift of workers to lower cost plans ($3.9 billion) and cost shift savings of

($5.2 billion). The average cost increase for private employers that currently offer coverage would be about $65 per worker. ***Figure 11*** presents the average change in costs per covered worker by firm size.

**Figure 11**
**Average Change in Employer Health Spending per Worker by Firm Size under the Authors' Proposal for Employers that Currently Offer Coverage**




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

## *7. Household Impacts*

The primary effects of the authors' proposal on families would be to reduce family premium payments and out-of-pocket spending for health services while increasing household tax payments. Premium payments would be reduced by about $162.5 billion as all families are eligible to receive tax credits for the purchase of insurance ***(Figure 12).*** Out-of-pocket spending also would be reduced by about $12.4 billion, primarily due to expanded coverage. There would be an increase in federal and state income taxes as the current tax exclusion for employee health insurance is replaced with the tax credit program. The net impact of these provisions would be a reduction in family health spending of about $83.9 billion (before wage effects).

As discussed above, the increases in costs to employers under the program are expected to be passed-on to workers in the form of reduced wages over time. This would reduce family incomes by about $9.1 billion after taxes. We count this reduction in after-tax income as an increase in family health spending. Thus, when the wage effects are considered, the savings to households falls to about $74.8 billion under the program.

There would be an increase in personal income taxes of $154.4 billion to finance the program. When these taxes are added to family costs, the program increases family health spending by about $79.6 billion. This is an average increase in family health spending of about $668 per family (***Figure 13***). Spending would, on average, increase across all age groups including the aged, except for a small decline in spending for persons under age 25. This reflects the fact that the income tax increase would be paid by all tax payers including those who are not affected directly by the program.

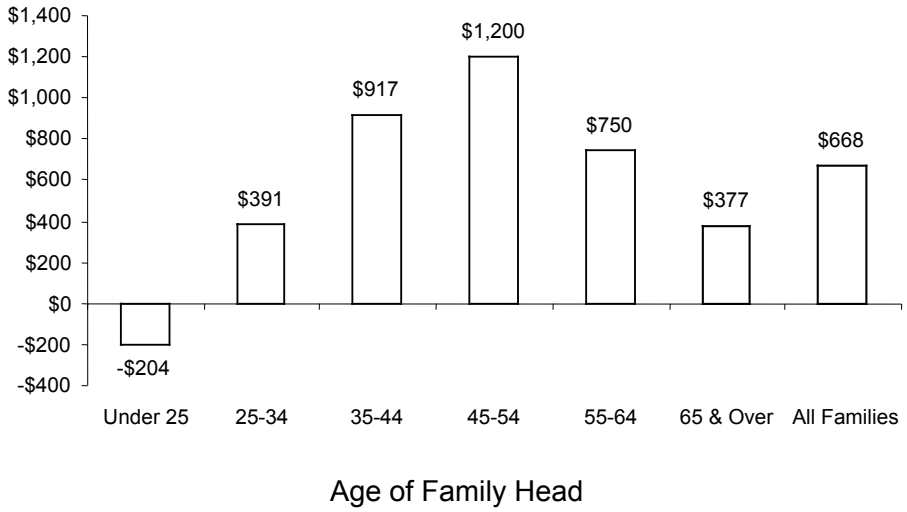
## Figure 12
## Impact of Authors' Proposal on Family Health Spending (in billions)

| | Without Wage Effects | With Wage Effects | With Income Tax Increase |
|---|---|---|---|
| **Change in Premiums** | ($162.5) | ($162.5) | ($162.5) |
| **Change in Out-of-pocket** | ($12.4) | ($12.4) | ($12.4) |
| **Elimination of Tax Exclusion** | 91.0 | 91.0 | 91.0 |
| **After Tax Wage Effects a/** | - - | $9.1 | $9.1 |
| **Income Tax to Fund Program** | - - | - - | $154.4 |
| **Net Change** | **($83.9)** | **($74.8)** | **$79.6** |

a/ The reduction in after-tax wage income resulting from the program is counted here as an increase in family health spending

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

## Figure 13
## Change in Average Family Health Spending under the Authors' Proposal in 2002: by Age of Family Head

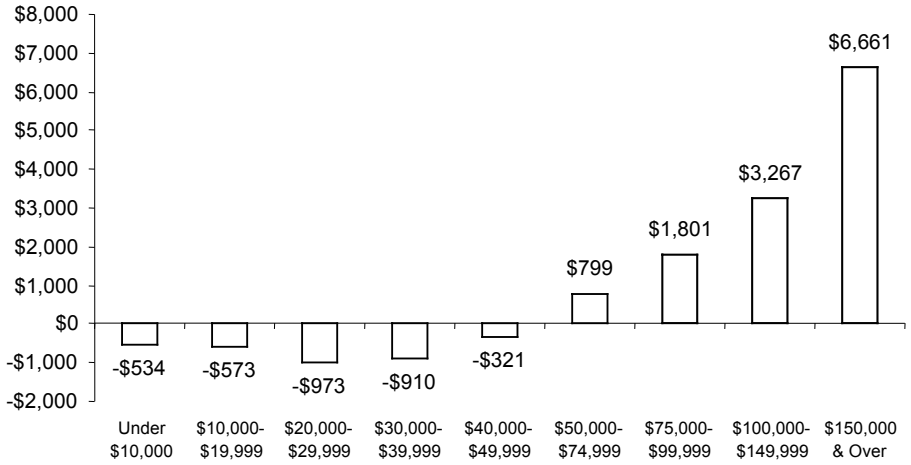



Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

The program would, on average, result in a reduction in health spending for families with annual incomes below $50,000. However, spending would increase on average for families at all income levels above $50,000. Due to the progressive nature of the income tax that is used to fund the program, the increase in health spending would be greatest among persons in higher income groups. For example, families with $150,000 or more in income would see a net increase in health spending of about $6,661 per family ***(Figure 14).***

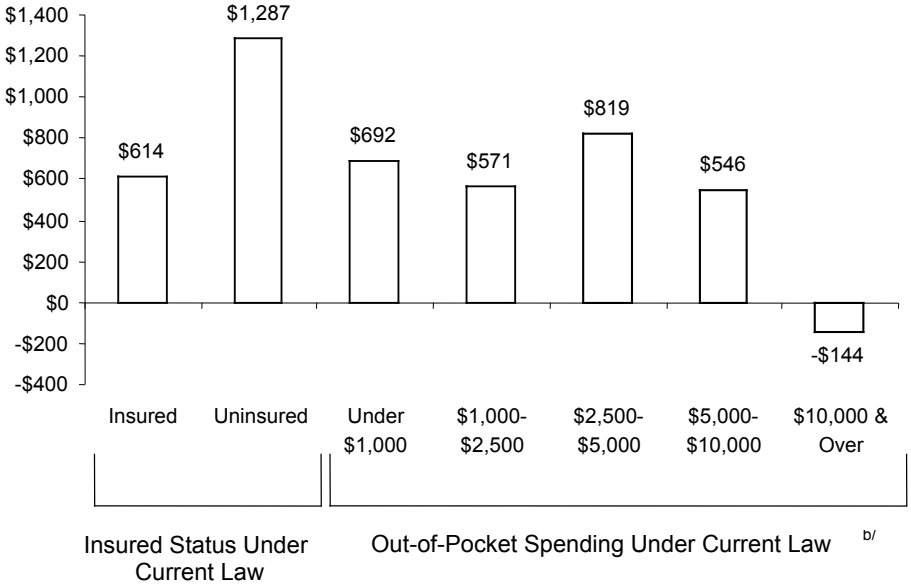
***Figure 15*** presents the average change in health spending per family by current insured status and family health spending under current law. ***Figure 16*** presents the distribution of newly insured persons by age and income.

**Figure 14**
**Change in Average Family Health Spending by Family Income**




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

**Figure 15**
**Change in Average Family Health Spending by Current Insured Status and Amount of Out-of-pocket Family Spending Under Current Law a/**




a/ The change in family health spending includes changes in out-of-pocket payments for health services, changes in premiums, after tax wage effects and taxes created for the program.
b/ Family out-of-pocket health spending under current law includes out-of-pocket spending for health services and family premium contributions.
Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

**Figure 16**
**Change in the Number of Uninsured, by Age and Family Income**
**(thousands)**

| | Number of Uninsured under Current Law | Change in Number of Uninsured | Number Remaining Uninsured |
|---|---|---|---|
| **Age** | | | |
| **Under 19** | 8,979 | 8,841 | 138 |
| **19-24** | 7,430 | 7,078 | 352 |
| **25-34** | 9,111 | 8,686 | 425 |
| **35-44** | 7,966 | 7,778 | 188 |
| **45-54** | 5,202 | 4,992 | 210 |
| **55-64** | 3,083 | 2,828 | 255 |
| **65 & Over** | 173 | 173 | 0 |
| **Family Income** | | | |
| **Under $10,000** | 4,153 | 3,387 | 766 |
| **$10,000-$19,999** | 6,650 | 6,441 | 209 |
| **$20,000-$29,999** | 7,425 | 7,287 | 138 |
| **$30,00-$39,999** | 6,126 | 5,976 | 150 |
| **$40,000-$49,999** | 3,995 | 3,926 | 69 |
| **$50,000-$74,999** | 6,384 | 6,296 | 88 |
| **$75,000-$99,999** | 3,399 | 3,311 | 88 |
| **$100,000-$149,999** | 1,906 | 1,851 | 55 |
| **$150,000 & over** | 1,906 | 1,901 | 5 |
| **Total** | **41,944** | **40,376** | **1,568** |

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

### *8. Expenditures in Future Years*

As discussed above, we estimate that national health spending would increase by about $52.1 billion if fully implemented in 2002. This is principally due to increased health services utilization among newly insured people. This spending increase is partially offset by savings of about $8.5 billion among currently insured persons due to changes in consumer incentives under the program (i.e., the use of a fixed tax credit effectively requires people to pay the full cost of enrolling in a higher cost plan). We also estimate that the increase in HMO enrollment resulting from the new financial incentives under the proposal would slow the rate of growth in health spending, resulting in savings for much of the affected population over-time.

The available research indicates that the rate of growth in health spending is reduced as the percentage of persons enrolled in HMOs increases. Based upon a review of these studies, we assume that each 10 percent increase in the number of persons enrolled in HMOs would result in a reduction in spending growth of 1.3 percent for hospital services and 0.6 percent for physicians' services.

The Centers for Medicare and Medicaid Services (CMS) projects that national health spending will increase from about $1.65 trillion in 2003 to about $3.00 trillion in 2012 under current law (***Figure 17***). Health spending would increase in 2003 by about $56 billion under the authors' proposal as newly insured persons become covered. However, the rate of growth in health spending would be reduced due to the financial incentives under the program so that by 2009, total health spending under the author's proposal would actually be less than under current law. The total net change in health spending over the ten-year period between 2003 through 2012 would be a net increase of about $88.4 billion.

**Figure 17**
**National Health Spending under the Authors' Proposal 2003-2012**
**(in billions)**

| | Current Policy | Net Increase(Decrease) | Authors' Proposal |
|---|---|---|---|
| **2003** | $1,653.4 | $55.7 | $1,709,1 |
| **2004** | $1,773.4 | $51.1 | $1,824.5 |
| **2005** | $1,902.2 | $41.8 | $1,944.0 |
| **2006** | $2,036.6 | $28.9 | $2,065.5 |
| **2007** | $2,174.9 | $17.6 | $2,192.5 |
| **2008** | $2,320.0 | $7.4 | $2,327.4 |
| **2009** | $2,476.1 | ($7.9) | $2,468.2 |
| **2010** | $2,639.2 | ($19.3) | $2,619.9 |
| **2011** | $2,815.8 | ($34.7) | $2,781.1 |
| **2012** | $3,004.4 | ($52.2) | $2,952.2 |

Source: Lewin Group estimates based upon "National Health Care Expenditure Projections: 2003-2012", by the Centers for Medicare and Medicaid Services (CMS), Office of the Actuary.

Total federal cost of tax credits under the author's proposed program would be $337.5 billion in 2003, growing to $581.8 billion by 2012 (***Figure 18***). This estimate reflects the impact of the new financial incentives under the proposal on program spending. These costs would be partly offset by funds that would have been used to fund the portions of Medicaid that are discontinued under the proposal, and the increase in tax revenues due to the elimination of the tax exclusion. The amount of new federal revenue required to fund the program would be $164.4 billion in 2003, rising to $241.7 billion in 2012.

## Figure 18
## Federal Health Spending under the Authors' Proposal (in billions)

| | Tax Credits a/ | Federal Program Savings b/ | Eliminate Tax Exclusion c/ | Amount Needed to Fund Program |
|---|---|---|---|---|
| **2003** | $337.5 | $90.7 | $82.4 | $164.4 |
| **2004** | $360.8 | $98.6 | $89.4 | $172.8 |
| **2005** | $385.2 | $107.2 | $96.4 | $181.6 |
| **2006** | $409.8 | $116.7 | $103.3 | $189.8 |
| **2007** | $434.4 | $127.0 | $109.8 | $197.6 |
| **2008** | $460.5 | $138.2 | $116.5 | $205.8 |
| **2009** | $488.6 | $150.4 | $123.6 | $214.6 |
| **2010** | $517.6 | $163.5 | $130.9 | $223.2 |
| **2011** | $548.7 | $177.8 | $138.6 | $232.3 |
| **2012** | $581.8 | $193.4 | $146.7 | $241.7 |

a/ Assumed to grow at the CMS estimate of growth in total acute care spending, reduced to reflect the impact of changes in the tax treatment of employer-provided health insurance.
b/ Assumed to increase at the rates projected by CMS for the Medicaid program.
c/ The revenues from eliminating the tax exclusion are assumed to grow at the CMS projected rate of growth in private insurance spending for this period.
Source: Lewin Group estimates based upon "National Health Care Expenditure Projections: 2003-2012", by the Centers for Medicare and Medicaid Services (CMS), Office of the Actuary.