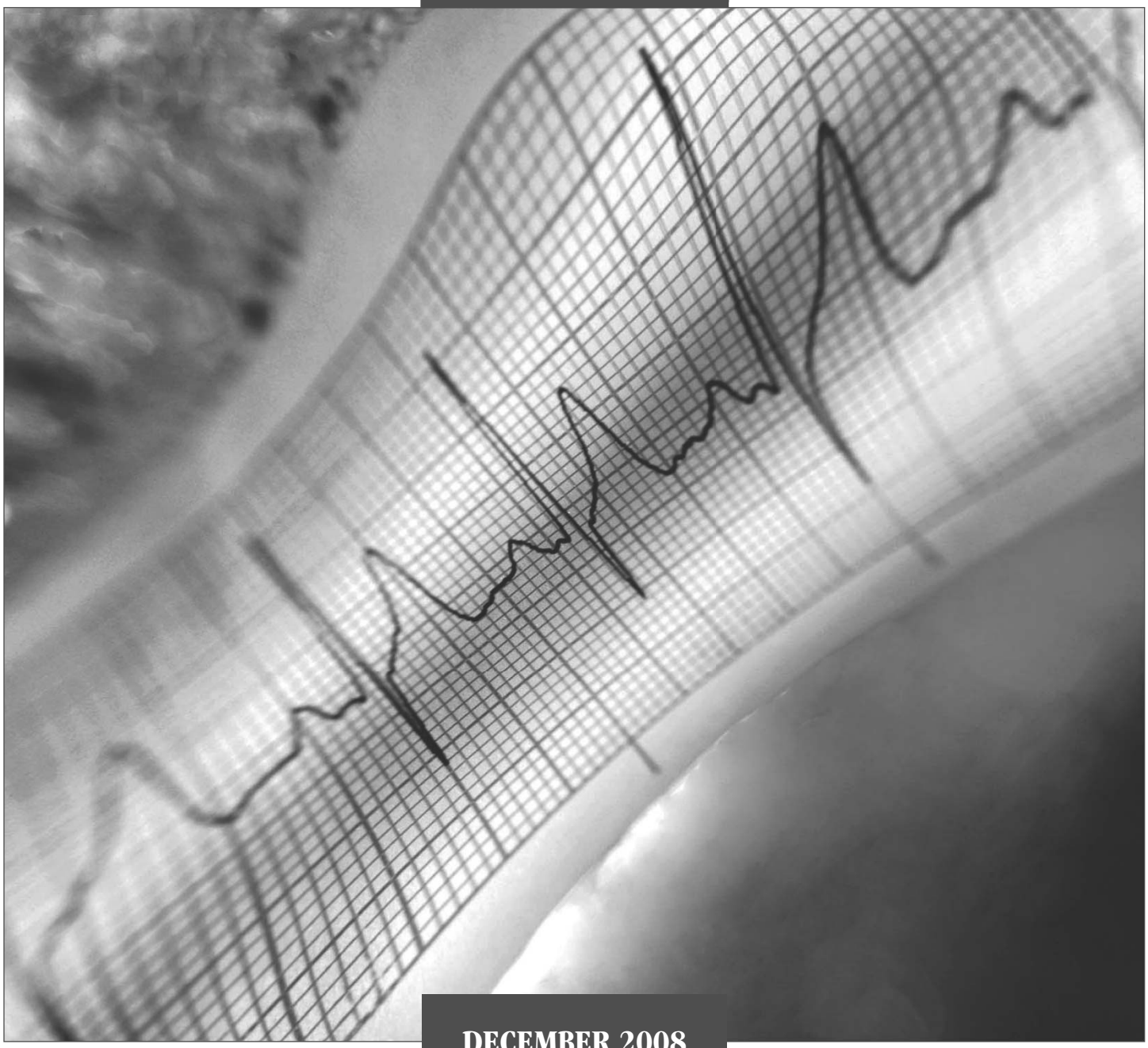
Exhibit 1

CONGRESS OF THE UNITED STATES
CONGRESSIONAL BUDGET OFFICE

CBO

Key Issues in Analyzing Major Health Insurance Proposals



DECEMBER 2008

Summary

Much of the health care provided in the United States confers tremendous benefits, extending and improving lives. But the high and rising costs for health care in this country impose an increasing burden on individuals, businesses, states, and the federal government, and a substantial number of people may have trouble paying for that care because they do not have health insurance. Those issues are related: Rising costs for health care make health insurance policies more expensive and thus more difficult to afford. Lack of insurance can limit access to care, but having insurance can increase spending by encouraging the use of services that provide limited health benefits. More generally, despite spending more per capita than other countries, the United States lags behind lower-spending countries on several metrics, including life expectancy and infant mortality. Indeed, evidence suggests that a substantial share of spending on health care contributes little if anything to the overall health of the nation, but finding ways to reduce such spending without also affecting services that improve health will be difficult.

Main Conclusions

Concerns about the number of people who are uninsured and about the rising costs of health insurance and health care have given rise to proposals that would substantially modify the U.S. health insurance system. The complexities of the health insurance and health care systems pose a major challenge for the design of such proposals and inevitably raise questions about their likely impact. To assist the Congress in its upcoming deliberations, this report seeks to provide useful background information as well as insights into how the Congressional Budget Office (CBO) would estimate the effects of such proposals on the federal budget, the number of people who have health insurance coverage, and spending for health care. Some of its main conclusions are as follows:

- The rising costs of health care and health insurance pose a serious threat to the future fiscal condition of the United States. Under current policies, CBO projects that federal spending on Medicare and Medicaid will increase from about 4 percent of gross domestic product (GDP) in 2009 to nearly 6 percent in 2019 and 12 percent by 2050. Most of that increase will result from growth in per capita costs rather than from the aging of the population.

- Without changes in policy, a substantial and growing number of nonelderly people (those younger than 65) are likely to be without health insurance. CBO estimates that the average number of nonelderly people who are uninsured will rise from at least 45 million in 2009 to about 54 million in 2019.

- Those problems cannot be solved without making major changes in the financing or provision of health insurance and health care. In considering such changes, policymakers face difficult trade-offs between the objectives of expanding insurance coverage and controlling both federal and total costs for health care.

- By themselves, premium subsidies or mandates to obtain health insurance would not achieve universal coverage. Proposals could, however, achieve near-universal coverage using a combination of approaches.

    - One option would establish an enforceable mandate for individuals to obtain insurance and would provide subsidies for lower-income households to help them pay their required premiums.

- Another option, under a voluntary system, would provide subsidies that cover a very large share of the expected costs of insurance for every enrollee and establish a process to facilitate enrollment (as is done in Medicare).

Other policies could achieve substantial reductions in the number of people who are uninsured at a lower budgetary cost.

- Serious concerns exist about the efficiency of the health care system, but no simple solutions are available to reduce the level or control the growth of health care costs. Steps to restructure the insurance market and to encourage people to purchase less extensive coverage could reduce the use of treatments that provide minimal benefits, but enrollees would face higher cost sharing or tighter management of their care.

- Other approaches—such as the wider adoption of health information technology or greater use of preventive medical care—could improve people's health but would probably generate either modest reductions in the overall costs of health care or increases in such spending within a 10-year budgetary time frame.

- In many cases, the current health care system does not give doctors, hospitals, and other providers of health care incentives to control costs. Significantly reducing the level or slowing the growth of health care spending would require substantial changes in those incentives.

Scope and Focus of This Report

In the near future, the Congress is expected to consider major proposals to modify the health insurance system. This report describes the assumptions that CBO would use in estimating the effects of key elements of such proposals on federal costs, insurance coverage, and other outcomes; the evidence upon which those assumptions are based; and, if the evidence points to a range of possible effects rather than a precise prediction, the factors that would influence where a proposal falls within those ranges.

This document does not provide a comprehensive analysis of any specific proposal; rather, it identifies and examines many of the critical factors that would affect estimates of a variety of proposals. In particular, it considers the types of issues that would arise in estimating the effects of proposals to:

- Provide tax credits or other types of subsidies to make insurance less expensive to the purchaser.

- Require individuals to purchase health insurance, typically paired with a new system of government subsidies.

- Require firms to offer health insurance to their workers or pay into a fund that subsidizes insurance purchases.

- Replace employment-based coverage with new purchasing arrangements or provide strong incentives for people to shift toward individually purchased coverage.

- Provide individuals with coverage under, or access to, existing insurance plans such as the Medicare program, either as an additional option or under a "Medicare-for-all" single-payer arrangement.

Wherever possible, the analysis presented here describes in quantitative terms how CBO would estimate the budgetary and other effects of such proposals. In other cases, it describes the components that a proposal would have to specify in order to permit estimation of its effects on federal spending or other outcomes. This report reflects the current state of CBO's analysis of and judgments about the likely response of individuals, employers, insurers, and providers to changes in the health insurance and health care systems. The details of particular policy specifications and the way in which they are combined, as well as new evidence or analysis related to the issues discussed here, could affect future CBO estimates of the effects of large-scale health insurance proposals.

Because such proposals could incorporate a number of the elements that are discussed in this report, they could have interactions that are difficult to predict. Those proposals could also affect both tax revenues and outlays. Estimates of the impact on revenues of proposals to change the federal tax code are prepared by the staff of the Joint Committee on Taxation (JCT) and would be

incorporated into any formal CBO estimate of a proposal's effects on the federal budget. In preparing this report, CBO consulted with the JCT staff about the behavioral considerations that are incorporated into both agencies' estimates.

The question of whether and how any net increases in federal spending for health care and health insurance would be financed by policy changes outside the health sector is beyond the scope of this report. Whether a proposal would make health insurance more affordable for a given individual or family would depend not only on its impact on the health insurance premiums that they face but also on the effect that its financing mechanisms would have on the household's budget. To the extent that such proposals would be financed by policy changes that fall outside the health sector—through tax increases or reductions in spending for other federal programs—those effects are not addressed here.

Background on Spending and Coverage

Health care costs are an important issue, not just for individuals and families seeking insurance coverage but also for the federal budget and the economy as a whole. Spending on health care and related activities will account for about 17 percent of gross domestic product in 2009—an expected total of $2.6 trillion—and under current law that share is projected to reach nearly 20 percent by 2017. Annual health expenditures per capita are projected to rise from about $8,300 to about $13,000 over that period. Federal spending accounts for about one-third of those totals, and federal outlays for the Medicare and Medicaid programs are projected to grow from $720 billion in 2009 to about $1.4 trillion in 2019.

Over the longer term, rising costs for health care represent the single greatest challenge to balancing the federal budget. The number of uninsured individuals is also expected to increase because health insurance premiums are likely to continue rising much faster than income, which will make insurance more difficult to afford.

Employment-Based Insurance

For several reasons, most nonelderly individuals obtain their insurance through an employer, and employment-based plans now cover about 160 million people, including spouses and dependents (see Summary Table 1). One fundamental reason such plans are popular is that they are subsidized through the tax code—because nearly all payments for employment-based insurance are excluded from taxable compensation and thus avoid income and payroll taxes. Another factor is the economies of scale that larger group purchasers enjoy, which reduce the average amount of administrative costs that are embedded in policy premiums; partly as a result, large employers are more likely than small employers to offer insurance to their workers. Overall, about three-fourths of workers are offered employment-based insurance and are eligible to enroll in it.

Another commonly cited reason for the popularity of employment-based policies is that employers offering coverage usually pay most of the premium—a step they take partly to encourage broad enrollment in those plans, which helps keep average costs stable. Ultimately, however, the costs of those employers' payments are passed on to employees as a group, mainly in the form of lower wages.

Other Sources of Coverage

Other significant sources of coverage include the individual insurance market and various public programs. Roughly 10 million people are covered by individually purchased plans, which have some advantages for enrollees; for example, they may be portable from job to job, unlike employment-based insurance. Even so, individually purchased policies generally do not receive favorable tax treatment; in most states, premiums may vary to reflect an applicant's age or health status, and applicants with particularly high expected costs are generally denied coverage.

Another major source of coverage is the federal/state Medicaid program and the related but smaller State Children's Health Insurance Program (SCHIP). Both programs provide free or low-priced coverage for children in low-income families and (to a more limited degree) their parents; Medicaid also covers poor individuals who are blind or disabled. On average, Medicaid and SCHIP are expected to cover about 43 million nonelderly people in 2009 (and there are also many people eligible for those programs who have not enrolled in them). Medicare also

Summary Table 1.

Sources of Insurance Coverage and Insurance Status of the Nonelderly Population, 2009

	Number (Millions)	Percent
	Source of Coverage	
Employment-Based[a]	160	61
Individually Purchased	10	4
Medicare	7	3
Medicaid[b]	43	17
Other[c]	12	4
	Insurance Status	
Insured, Any Source[d]	216	83
Uninsured	45	17

Source: Congressional Budget Office's health insurance simulation model.

Note: The nonelderly population (those younger than 65) excludes people in institutions and residents of U.S. territories.

a. Includes coverage obtained through local, state, and federal employers.

b. Includes the State Children's Health Insurance Program.

c. Includes military and other sources of coverage.

d. The sum of people by their sources of coverage exceeds the total number who are insured because about 14.5 million people are covered by more than one source at a time.

covers about 7 million people younger than 65 who are disabled or have severe kidney disease. About 12 million people have insurance coverage from various other sources, including federal health programs for military personnel. The total number of nonelderly people with health insurance at any given point in 2009 is expected to be about 216 million.

Approaches for Reducing the Number of Uninsured People

Concerns about the large number of people who lack health insurance have generated proposals that seek to increase coverage rates substantially or achieve universal or near-universal coverage. Two basic approaches could be used:

- Subsidizing health insurance premiums, either through the tax system or spending programs, which would make insurance less expensive for people who are eligible; or
- Establishing a mandate for health insurance, either by requiring individuals to obtain coverage or by requiring employers to offer health insurance to their workers.

By themselves, premium subsidies or mandates to obtain health insurance would not achieve universal coverage. Those approaches could be combined and could be implemented along with provisions to facilitate enrollment in ways that could achieve near-universal coverage.

Subsidizing Premiums

Whether new subsidies are delivered through the tax system or a spending program, several common issues arise. Trade-offs exist between the share of the premium that is subsidized, the number of people who enroll in insurance as a result of the subsidies, and the total costs of the subsidies. As the subsidy rate increases, more people will be inclined to take advantage of them, but the higher subsidy payments will also benefit those who would have decided to obtain insurance anyway. Beyond a certain point, therefore, the cost per newly insured person can grow sharply because a large share of the additional subsidy payments is going to otherwise insured individuals.

To hold down the costs of subsidies, the government could limit eligibility for subsidy payments to individuals who are currently uninsured. That restriction, however, would create incentives for insured individuals to drop their coverage. Some proposals might try to distinguish between people who become uninsured in response to subsidies and those who would have been uninsured in the absence of a government program (for example, by imposing waiting periods for individuals who were previously enrolled in an employment-based plan), but such proposals could be very difficult to administer. In addition, providing benefits only to the uninsured might be viewed as unfair by people with similar income and family responsibilities who purchase health insurance and are therefore ineligible for the subsidies.

Another approach to limiting costs would target subsidies toward the lower-income groups, who are most likely to be uninsured otherwise, but such approaches can also have unintended consequences that affect the costs of a proposal. If eligibility was limited to people with income below a certain level, then those with income just above the threshold would have strong incentives to work less or hide income in order to qualify for the subsidies or maintain their eligibility. Phasing out subsidies gradually as income rises would reduce those incentives, but it would increase the amount of subsidy payments that go to individuals and families who would have had insurance in any event.

Restructuring the Existing Tax Subsidies. Tax subsidies could be restructured to expand coverage in several ways. For example, the current tax exclusion for employment-based health insurance could be replaced with a deduction or tax credit to offset the costs of insurance, and tax subsidies could be extended to include policies purchased in the individual insurance market. That step would sever the link between employment and tax subsidies for private health insurance and could give similar people the same subsidy whether or not they were offered an employment-based health plan.

Deductions and credits differ, however, in their effectiveness at reaching the uninsured. An income tax deduction might provide limited benefits to low-income individuals because, like the existing exclusion, its value is less for those in lower tax brackets. In contrast, tax credits can be designed to provide lower- and moderate-income taxpayers with larger benefits than they would receive from tax deductions or exclusions. An important question regarding tax credits—particularly for lower-income people who pay relatively little in income taxes and are also more likely to be uninsured—is whether the credits would be refundable and therefore fully available to individuals with little or no income tax liability.

For the same budgetary costs, a refundable tax credit might be more effective at increasing insurance coverage, both because it can be designed to provide a larger benefit to people who have low income than they receive under current law and because those recipients might be more responsive to a given subsidy than are people with higher income. Still, the effect on coverage rates might be limited if people do not receive refundable tax credits before their premium payments are due.

Providing Subsidies Through Spending Programs. The government could seek to increase coverage rates by spending funds to subsidize insurance premiums. New subsidies could be provided implicitly by expanding eligibility for Medicare, Medicaid, or SCHIP or explicitly by creating a new program. To hold costs down, benefits could be targeted on the basis of income, assets, family responsibilities, and insurance status. Targeting benefits, however, would require program administrators to certify eligibility and enforce the program's rules, which would affect coverage and the program's costs.

The Effects of Subsidy Proposals. Proposals to subsidize insurance coverage would affect decisions by both employers and individuals. Employers' decisions to offer insurance to their workers reflect the preferences of their workers, the cost of the insurance that they can provide, and the costs of alternative sources of coverage that workers would have. Smaller firms appear to be more sensitive to changes in the cost of insurance than are larger employers. Subsidies that reduce the cost of insurance offered outside the workplace would cause some firms to drop coverage or reduce their contributions. When deciding whether to enroll in employment-based plans, workers would consider the share of the premium that they pay as well as the price and attractiveness of alternatives. The available evidence indicates that a small share of the population would be reluctant to purchase insurance even if subsidies covered nearly all of the costs.

Mandating Coverage

In an effort to increase the number of people who have health insurance or to achieve universal or near-universal coverage, the government could require individuals to obtain health insurance or employers to offer insurance plans. Employer mandates could include a requirement that employers contribute a certain percentage of the premium, which would encourage their workers to purchase coverage. To the extent that the required contributions exceeded the amounts that employers would have paid under current law, offsetting reductions would ultimately be made in wages and other forms of compensation.

The impact of a mandate on the number of people covered by insurance would depend on its scope, the

extent of enforcement, and the incentives to comply, as well as the benefits that enrollees would receive. Individual mandates, for example, could be applied broadly to the entire population of the United States or to a specific group, such as children; employer mandates might vary by the size of the firm.

Penalties would generally increase individuals' incentives to comply with mandates, but when deciding whether to obtain insurance, people would also consider the likelihood of being caught if they did not comply. Data from the tax system and from other government programs, where overall rates of compliance range from roughly 60 percent to 90 percent, indicate that mandates alone would not achieve universal coverage, largely because some people would still be unwilling or unable to purchase insurance.

Facilitating Enrollment

Simplifying the process of enrolling in health insurance plans or applying for subsidies could yield higher coverage rates and could also increase compliance with a mandate to obtain coverage. One approach would be to enroll eligible individuals in health insurance plans automatically, giving them the option to refuse that coverage or to switch to a different plan. Automatic enrollment procedures have been found to increase participation rates in retirement plans and government benefit programs. Automatic enrollment requires the government, an employer, or some other entity to determine the specific plan into which people will be enrolled, however, and those choices may not always be appropriate for everyone.

Factors Affecting Insurance Premiums

Premiums for employment-based plans are expected to average about $5,000 per year for single coverage and about $13,000 per year for family coverage in 2009. Premiums for policies purchased in the individual insurance market are, on average, much lower—about one-third lower for single coverage and one-half lower for family policies. Those differences largely reflect the fact that policies purchased in the individual market generally cover a smaller share of enrollees' health care costs, which also encourages enrollees to use fewer services. An offsetting factor is that average administrative costs are much higher for individually purchased policies. The remainder of the difference in premiums probably arises because people who purchase individual coverage have lower expected costs for health care to begin with.

The federal costs of providing premium subsidies, or the effects of those subsidies on the number of people who are insured, would depend heavily on the premiums charged. Premiums reflect the average cost that any insurer—public or private—incurs, and those costs are a function of several factors:

- The scope of the benefits the coverage includes and its cost-sharing requirements;
- The degree of benefit management that is conducted;
- The administrative costs the insurer incurs; and
- The health status of the individuals who enroll.

Insurers' costs also depend on the mechanisms and rates used to pay providers and on other forces affecting the supply of health care services. Proposals could affect many of those factors directly or indirectly. For example, the government might specify a minimum level of benefits that the coverage must provide in order to qualify for a subsidy or fulfill a mandate; such a requirement could have substantial effects on the proposal's costs or its impact on coverage rates.

Design of Benefits and Cost Sharing

Health insurance plans purchased in the private market tend to vary only modestly in the scope of their benefits—with virtually all plans covering hospital care, physicians' services, and prescription drugs—but they vary more substantially in their cost-sharing requirements. A useful summary statistic for comparing plans with differing designs is their "actuarial value," which essentially measures the share of health care spending for a given population that each plan would cover. Actuarial values for employment-based plans typically range between 65 percent and 95 percent, with an average value between 80 percent and 85 percent. Cost-sharing requirements for

52 percent in 1996, rose to 58 percent in 2001, and fell back to 52 percent in 2008. Studies have attributed the recent decline in enrollment to a combination of modest reductions in the number of employers offering insurance, shifts in employment toward firms and industries that are less likely to offer health insurance coverage, and a reduction in enrollment rates among workers who are offered coverage. The estimated impact of each of those factors varies, however, depending on the specific years examined, the data used, and the methodology employed.

One source of employment-based health insurance that has received considerable attention is the Federal Employees Health Benefits (FEHB) program, which provides coverage to about 8 million active and retired federal employees in 2008. Under that program, several private health insurance plans are available nationwide, and in most regions employees have a range of local plans available to them as well. The federal government covers 75 percent of the cost of each participating plan up to a limit set at 72 percent of the national average premium; to purchase a policy more expensive than that, the enrollee has to pay the added costs (although those payments may also be excluded from taxable income).[11] Like employees of private firms that offer a choice of insurance plans, federal workers may generally sign up for coverage or change plans only during an annual open-enrollment season—a rule that limits their opportunities to wait until they develop a health problem to enroll or to switch plans for health reasons and thus limits the degree of adverse selection that can occur.

Although employment-based insurance has certain advantages, the central role of employers in sponsoring coverage also has disadvantages. Unlike federal workers, many employees are not offered a choice of insurance plans, and others may have only a few plans from which to select, so the plan in which they enroll might not fit their preferences. Furthermore, employees and their dependents typically have to change plans when changing jobs and could become uninsured if their new employer does not offer coverage—potentially making them reluctant to switch jobs in the first place (a phenomenon known as "job lock").[12] In addition, employees who become disabled or too sick to keep their job may eventually lose their employment-based coverage.

Individually Purchased Insurance. Overall, CBO estimates that about 10 million nonelderly individuals will be covered by a policy purchased in the individual insurance market in 2009. In principle, anyone may purchase coverage in that market—to cover only themselves or their family as well—but in practice that option may be more attractive to some people than to others. (Such coverage is sometimes called "nongroup" insurance to distinguish it from group coverage, which is primarily employment based.)

The potential for adverse selection may be stronger in the individual market than in the employment-based market, partly because people can apply for individual insurance at any time and may therefore wait until a health problem arises before seeking coverage and partly because applicants do not have to be healthy enough to work. To address those possibilities, insurers usually "underwrite" the policy—a process by which they assess the health risk of applicants. Although most applicants end up being quoted a standard premium rate (which usually varies by age), underwriting can result in adjustments to premiums, adjustments to benefits (for example, to exclude coverage of known health conditions), or denials of coverage. As a result, individuals who have more health problems may face higher premiums when they apply for coverage. Some states, however, prohibit or limit those practices—which generally has the effect of reducing premiums charged to older or less healthy applicants and raising premiums for younger and healthier applicants (as discussed further in Chapter 4).

Individual insurance products have some other advantages and disadvantages compared with employment-based coverage. Some applicants may be able to obtain basic insurance protection (such as "catastrophic coverage" plans) in the individual market at a relatively low cost. That market generally offers consumers a greater choice of plans, and the coverage may be portable from one job to another. Insurers incur greater administrative costs for policies sold in the individual market, however,

11. For more information, see Mark Merlis, "The Federal Employees Health Benefits Program: Program Design, Recent Performance, and Implications for Medicare Reform" (briefing prepared for the Henry J. Kaiser Family Foundation, May 30, 2003).

12. Workers who previously held employment-based insurance may seek coverage in the individual insurance market, and insurers must generally offer them a policy if they apply, but some workers may find the terms of that coverage unattractive. See Chapter 4 for additional discussion.

and those costs are built into the policy premiums. Compared with the enrollment process for an employment-based plan, the effort required of applicants to search for a policy and sign up for coverage in the individual market can be considerably greater. In general, individually purchased coverage does not receive favorable tax treatment, which also makes its effective price higher.[13]

Reflecting those disadvantages, participation in the individual insurance market is relatively low. Only about 1 percent of nonelderly adults who are offered employment-based coverage (either by their own employer or through a spouse) elect to purchase individual coverage. Even among people who lack other coverage options, only about 20 percent elect to purchase a policy in the individual market; the rest are uninsured. In many cases, individually purchased policies are held for relatively short periods of time—serving to cover individuals between jobs, for a short period following college (a point at which children may become ineligible for coverage under their parents' plan), or between retirement and age 65 (the age of eligibility for Medicare).

Medicare. Medicare provides coverage for about 37 million people who are age 65 or older, and it also covers about 7 million nonelderly people who are disabled (and generally become eligible after a two-year waiting period) or have severe kidney disease.[14] In 2008, about 80 percent of Medicare's beneficiaries are insured through the traditional fee-for-service program, which pays providers for services directly using prices set administratively; the rest have chosen to receive coverage through private insurers that contract with Medicare to provide program benefits in return for a fixed monthly payment per enrollee (known as the Medicare Advantage option). About 3 percent of people under age 65 are covered by Medicare (see Table 1-1 on page 4), but their average costs to the program are substantial—more than $35,000 per person in 2007 for those with kidney failure and roughly $8,000 per person for other disabled enrollees.

When it was created, Medicare had two primary components: Part A, which generally covers hospital care and other services provided by institutions; and Part B, which generally covers physicians' services and various forms of outpatient care. Enrollment in Part A is free of charge and essentially automatic for individuals (and their spouses) who have sufficient earnings subject to payroll taxes to qualify for Social Security benefits; certain others may enroll but must pay a monthly premium. To participate in Part B, enrollees must pay a monthly premium that covers about 25 percent of the program's average costs. Although participation is voluntary, seniors who choose not to participate in Part B when they are first eligible are subject to penalties if they decide to enroll at a later date—penalties that are intended to discourage eligible individuals from waiting to develop a health problem before they enroll. As a result of those provisions, nearly 95 percent of individuals who are eligible to enroll in Part B do so. Many of those who do not enroll have retiree coverage from a former employer that limits the benefits they would receive from enrolling in Part B (and may also exempt them from the late-enrollment penalty).

A voluntary outpatient prescription drug benefit—known as Part D—was added to Medicare in 2006; its premium subsidy and penalty for late enrollment are similar to Part B's. About 70 percent of the people who are eligible to participate in Part D have chosen to do so.[15] Analysis by the Centers for Medicare and Medicaid Services (CMS) indicates that a majority of those nonenrollees have drug coverage from another source that is at least as comprehensive as the Medicare benefit, but about 10 percent of the Medicare population appears to lack substantial drug coverage.

Medicaid and the State Children's Health Insurance Program. Medicaid is the main source of health insurance coverage for Americans who have very low income, and the smaller State Children's Health Insurance Program (SCHIP) provides coverage for children in families that have somewhat higher income. Unlike the Medicare program, which does not take into account income or assets when determining eligibility and is federally financed, Medicaid and SCHIP are needs-based assistance programs that are jointly financed by the federal government and state governments.

13. Exceptions include self-employed individuals, who may deduct the costs of their health insurance from their taxable income, and individuals who claim itemized medical deductions in excess of 7.5 percent of their adjusted gross income. See Chapter 2 for additional discussion.

14. According to the most recent estimates from the Census Bureau, about 700,000 elderly people, or roughly 2 percent of individuals age 65 or older, were uninsured in 2007.

15. That figure includes retirees who continue to receive drug coverage from a former employer if that employer receives a subsidy payment from Medicare on their behalf.

CBO estimates that at any given point in 2009, roughly 64 million nonelderly individuals will be eligible for Medicaid or SCHIP coverage and that about 43 million will be enrolled.[16] Eligibility for Medicaid was originally limited to very low income families with dependent children and to poor elderly or disabled individuals. Over the past two decades, coverage has been extended to children in families with somewhat higher income and to pregnant women. Nonelderly, nondisabled adults who have no children are generally ineligible for the program. Able-bodied parents and children represent about three-fourths of all Medicaid enrollees, but about 70 percent of the program's spending is for the remaining enrollees who are either elderly or disabled and have low income and few assets.

Subject to broad federal requirements governing eligibility and benefits, the Medicaid program is largely administered by the states, and thus its specific features may vary considerably from state to state. On average, the federal government covers about 57 percent of the costs of the health care services received by enrollees (the share varies among states and is higher for states with relatively low per capita income). State Medicaid programs cover a comprehensive set of services, including hospital care (both inpatient and outpatient), physicians' services, nursing home care, home health care, and certain additional services for children. States have the authority to cover other services and populations and have used that authority extensively.[17] They may also apply to the federal government for waivers from various federal Medicaid rules.

SCHIP was established in 1997 to provide coverage to children whose family income is above the eligibility levels for Medicaid. States generally cover children in families that have income up to 200 percent of the federal poverty level (or about $44,000 for a family of four in 2009), but some states have higher income limits and some cover parents as well as their children. Like Medicaid, SCHIP is jointly funded by the federal government and the states, but the federal share of costs is higher for SCHIP—covering 70 percent of health care claims, on average. States have a fair amount of discretion in designing and implementing their programs: They may expand Medicaid, create a new state system specifically for SCHIP, or use some combination of the two approaches.[18]

SCHIP is currently authorized in law through March 2009. Consistent with statutory guidelines, CBO assumes in its baseline spending projections that federal funding for the program in later years will continue at $5.0 billion, the base amount provided for the first half of fiscal year 2009. In fiscal year 2008, the program's budget authority was $6 billion and its outlays were about $7 billion. Because average costs per enrollee are expected to rise, CBO projects that average enrollment would decline from a peak of about 5.3 million in 2008 to about 2 million in 2018 under that assumption about future funding. (References to Medicaid in the remainder of this chapter also include SCHIP.)

Other Sources of Coverage. A significant number of people obtain insurance coverage from various other sources including the military, universities (for students), and other organizations. CBO estimates that roughly 12 million people will be covered under such arrangements in 2009. Although military coverage could be considered a form of employment-based insurance, it is typically counted separately. The Department of Veterans Affairs provides some health care to military veterans, but its programs are not considered a comprehensive health insurance plan; similarly, the Indian Health Service provides some care to Native Americans and Alaska natives but is not counted as a source of health insurance (such programs are discussed more extensively in Chapter 6).

16. That figure represents average enrollment and excludes nonelderly individuals living in institutions (such as nursing homes) and people living in U.S. territories. CBO has also projected that the total number of individuals enrolled in Medicaid at any point during 2009 (including elderly and institutionalized enrollees and residents of territories) will be 65 million, of which about 59 million will be nonelderly. Many of those individuals will be enrolled in the program for only part of the year.

17. According to one estimate, total spending on optional populations and benefits accounted for about 60 percent of the program's expenditures in 2001. Of that total, 30 percent was spent to provide optional benefits to mandatory groups; 50 percent, to provide mandatory benefits to optional groups; and 20 percent, to provide optional benefits to optional groups. See Kaiser Commission on Medicaid and the Uninsured, *Medicaid Enrollment and Spending by "Mandatory" and "Optional" Eligibility and Benefit Categories* (Washington, D.C.: Henry J. Kaiser Family Foundation, June 2005), p. 11.

18. For additional information, see Congressional Budget Office, *The State Children's Health Insurance Program* (May 2007).

Table 2-1.

Distribution of the Nonelderly Population, by Insurance Status, Family Income, and Family Structure, 2009

(Millions)

Family Income Relative to Poverty Level (Percent)	Children		Adults				Total	
			With Children		Without Children			
	Insured	Uninsured	Insured	Uninsured	Insured	Uninsured	Insured	Uninsured
Below 100	17.2	2.7	6.5	3.5	7.3	6.9	30.9	13.1
100 to 200	15.5	3.4	10.8	5.8	9.1	6.6	35.3	15.8
200 to 300	11.9	1.8	12.9	2.9	10.9	3.6	35.7	8.3
300 to 400	9.6	0.9	12.3	1.3	10.3	2.0	32.2	4.2
Above 400	17.2	0.8	28.9	1.0	36.1	1.9	82.2	3.7
Total	**71.3**	**9.6**	**71.3**	**14.5**	**73.7**	**20.9**	**216.3**	**45.1**

Source: Congressional Budget Office's health insurance simulation model.

Note: Children are age 22 or younger.

as income increases would reduce, but would not eliminate, those incentives. At the same time, the more gradually the subsidies were phased out, the greater the number of people who would be eligible for them—and the more likely that subsidy payments would go to those who would have had insurance in any event. The number of uninsured—regardless of the individual's age or the presence of children in his or her home—gradually declines as family income rises above 200 percent of the federal poverty level. Still, nearly 4 million uninsured individuals have family income that is greater than 400 percent of the federal poverty level; however, over 80 million insured individuals have income that exceeds that level (see Table 2-1).

Whatever eligibility rules are applied, subsidy systems generally need to establish methods for determining who is eligible, how much of a subsidy each person receives, and how the subsidy will be delivered. In particular, basing subsidies on income requires a system for measuring and verifying income, and trade-offs can arise between the timeliness and accuracy of that information. Verifying eligibility could impose costs not only on the agencies that administer the programs but also on the individuals applying for subsidies who might choose to forgo benefits rather than bother with administrative hassles and the perceived stigma of participating in such programs. Subsidy payments could go directly to individuals or could instead be channeled through insurers, employers, state governments, or other intermediaries.

The design issues raised by various subsidy systems and their implications for the federal budget can be illustrated by examining more closely the two largest subsidies currently provided to the nonelderly population: the tax exclusion for employment-based insurance and the Medicaid program (along with the smaller SCHIP program). Both the tax exclusion and Medicaid also illustrate the many challenges involved in providing subsidies to lower-income individuals and families, who typically have limited tax liabilities—and thus might derive little benefit from certain types of tax-based subsidies—but may find it burdensome to apply for programs like Medicaid or SCHIP or may be ineligible for those two programs under current rules.

Subsidizing Premiums Through the Tax System

Most workers receive a subsidy through the tax system when they purchase private health insurance through their employer. Employers' payments for health insurance are a form of compensation, but those payments are exempt from income and payroll taxes (as are most employees' payments for their share of health insurance premiums). Changes to those subsidies could have substantial effects on coverage rates and the federal budget.

Current Tax-Based Subsidies

The favorable tax treatment currently provided for health insurance purchased through an employer represents the

largest single source of federal premium subsidies for the nonelderly population. Employers may compensate their employees by paying health insurance premiums in lieu of cash wages, but the two types of compensation receive very different tax treatment.[2] Employers may deduct the costs of providing that coverage as a business expense—just as they deduct employees' wages and other forms of compensation—and thus those payments are not subject to corporate income taxes. But unlike wages, the costs that employers pay for health insurance are also excluded from the taxable income and earnings of the covered employees. That portion of employees' compensation is therefore exempt from individual income and payroll taxes.

Partly as a result of that favorable tax treatment, employers that offer health insurance to their workers typically pay a substantial share of the premium for that coverage; that is, the amount that employees pay directly usually covers a relatively small fraction of the total premium. Many firms also offer their workers a "cafeteria plan," which allows employees to choose cash or other taxable benefits in lieu of receiving nontaxable benefits. (Such plans are referred to as Section 125 plans, after the section of the tax code that authorizes them.) Under that arrangement, employees are able to exclude the portion of the health insurance premium that they pay from their taxable income—so for most workers, the full cost of the employer-sponsored plan receives favorable tax treatment.[3]

The subsidy provided by the current tax exclusion shows up as a reduction in taxes (commonly referred to as a tax expenditure) rather than as an overt payment. The manner in which the tax exclusion subsidizes health insurance can be seen by comparing the tax liabilities of two otherwise identical workers employed at different firms. Both workers receive $40,000 in compensation from their respective employers in 2009, but that compensation—which is a combination of wages, employers' contributions for payroll taxes, and fringe benefits—takes different forms at the two firms:

- Employee A works for a firm that does not offer health insurance. He receives about $37,160 in cash wages, and his employer pays the remaining compensation—about $2,840—to the government in the form of payroll taxes. Employee A pays $5,000 for a health insurance plan in the individual market.

- Employee B works for a firm that offers health insurance. She receives about $32,500 in wages, and her employer pays nearly $2,500 in payroll taxes on her wages. In addition, she has an employment-based health insurance plan valued at $5,000 per enrollee.

For simplicity, assume that both workers have no other sources of income and are in the 15 percent income tax bracket; that the employee's and the employer's portions of the Social Security and Medicare payroll taxes (which have a combined rate of 15.3 percent) are ultimately paid by the workers; and that the costs of the second firm's health plan are borne evenly across its workforce.[4]

Although the two workers receive the same total compensation and have comparable health insurance coverage, their tax liabilities differ. Employee A, who purchases health insurance in the individual market, pays $9,439 in income and payroll taxes, or $1,407 more than the worker who receives part of her compensation in the form of health insurance premiums. For Employee B, federal taxes have effectively reduced the cost of insurance by more than 28 percent, to $3,593 (see Table 2-2). The effective subsidy rate increases by several percentage points if the employee lives in one of the 41 states (or the District of Columbia) that have an individual income tax; those states generally follow federal definitions of earnings and other income and thus exclude employers' contributions for health insurance from their calculation of taxable income.[5]

2. See Chapter 1 for further discussion of the incidence of employers' contributions for health insurance.

3. Employees of a firm that does not offer cafeteria plans cannot exclude their share of health insurance premiums from taxable income for income and payroll tax purposes. However, they may be able to claim those premiums as an itemized deduction on their income tax return if their total medical expenses exceed 7.5 percent of adjusted gross income.

4. Although considered part of compensation, employers' contributions for payroll taxes are not subject to income taxes or the employees' portion of payroll taxes.

5. An offsetting consideration is that excluding health insurance premiums from taxable wages reduces future Social Security benefits, which are based on average earnings, at the same time that it reduces payroll tax payments (see Chapter 6 for further discussion).

Table 2-2.

Illustrative Tax Subsidy for Employment-Based Health Insurance for a Single Worker Who Receives $40,000 in Total Compensation, 2009

(Dollars)

	Employee A: Pays $5,000 for Individual Health Insurance	Employee B: Receives $5,000 of Employment-Based Health Insurance	Difference
Compensation			
Cash wages	37,157	32,513	4,644
Premiums for employment-based health insurance	0	5,000	-5,000
Employers' contribution for payroll taxes	2,843	2,487	355
Total compensation	40,000	40,000	0
Premiums for Health Insurance in Individual Market	5,000	0	5,000
Income Tax			
Adjusted gross income	37,157	32,513	4,644
Minus personal exemption	3,650	3,650	0
Minus standard deduction	5,700	5,700	0
Taxable income	27,807	23,163	4,644
Income tax	3,754	3,057	697
Payroll Tax			
Employee's contribution at 7.65 percent	2,843	2,487	355
Employer's contribution at 7.65 percent	2,843	2,487	355
Total payroll tax	5,685	4,974	711
Total Income and Payroll Taxes	9,439	8,031	1,407
After-Tax Cost of Health Insurance	5,000	3,593	1,407
Subsidy as a Percentage of Costs of Health Insurance	0	28	-28

Source: Congressional Budget Office.

Note: To simplify the example, both workers are assumed to be unmarried, to have no dependents, to receive $40,000 in total compensation, and to have no sources of income other than wages and salaries.

The aggregate effects of that exclusion on the federal budget are large, exceeding federal spending on Medicaid. The Joint Committee on Taxation has estimated that the total federal tax expenditure associated with the exclusion for employment-based health insurance was $246 billion in 2007, consisting of $145 billion in individual income taxes and $101 billion in payroll taxes.[6] (By comparison, the federal government spent over $195 billion on Medicaid in 2007.) In addition, the federal government incurs an additional tax expenditure of about $5 billion annually by allowing self-employed individuals to deduct the costs of health insurance from their taxable income (but health insurance costs for the self-employed are not deductible for purposes of payroll taxes). However, the magnitude of the estimated tax expenditures is not the same as the increase in revenues that would result from repealing the current exclusion or the deduction for the self-employed, because the calculation of the tax expenditures does not account for any changes in taxpayers' behavior that would result if the exclusion was repealed. (The revenue gain from repeal would be less than the estimated tax expenditures because some individuals would find other ways to reduce their tax liabilities if the exclu-

6. Joint Committee on Taxation, *Tax Expenditures for Health Care*, JCX-66-08 (July 30, 2008).

sion was repealed; some individuals, for example, might claim their health insurance premiums as an itemized deduction.)

The current tax treatment of health insurance premiums encourages employers to offer health insurance to their employees and encourages employees to enroll in those plans, but it has also raised several concerns. In particular, the exclusion does not provide benefits for health insurance evenly. Individuals with the same income and similar family responsibilities can receive very different tax benefits for medical costs. Employees who can exclude premiums for employment-based insurance from payroll taxation, as well as from individual income taxes, typically receive more generous tax subsidies than do self-employed individuals. Employees who work for firms that do not offer insurance do not benefit from the exclusion.

In addition, the current system provides different tax subsidies to people at different income levels. Because the rate structure of the income tax is progressive—that is, as income rises, each additional dollar of income may be taxed at a higher rate—the value of the exclusion generally grows as income increases. If, in the example above, the single employee with an employer-sponsored health insurance policy worth $5,000 had earned $70,000 in total compensation instead of $40,000, that individual would probably be in the 25 percent rate bracket; being in that higher bracket would increase the total tax savings by $465 (from $1,407 to $1,872) and raise the federal tax subsidy to over 37 percent. The share of the premiums that the federal exclusion offsets can be somewhat lower at higher levels of income if taxpayers reach the wage ceiling for Social Security payroll taxes ($106,800 in 2009). The value of the exclusion represents a larger *percentage* of income for middle-income households than for high-income households, however, largely because average premiums for health insurance do not vary substantially with income and therefore decline as a share of income as income rises.

Although the exclusion of employer-paid premiums is by far the largest tax expenditure related to health care, two others worth noting are the itemized deduction for medical expenses and the health coverage tax credit that is available for workers displaced from their jobs by international trade. (For a general discussion of the key differences between tax exclusions, tax deductions, and tax credits, see Box 2-1.)

Taxpayers who **itemize deductions** on their income tax return may deduct unreimbursed medical expenses, including any premiums and out-of-pocket expenses that they paid out of after-tax income. The deduction is generally limited to expenses in excess of 7.5 percent of adjusted gross income; for example, a taxpayer with $50,000 in adjusted gross income could deduct medical costs in excess of $3,750. Furthermore, the total amount of itemized deductions is gradually reduced for taxpayers with adjusted gross income above $166,800 in 2009. In 2007, the tax expenditure for the itemized deduction for medical expenses was about $9 billion.

The **health coverage tax credit** covers up to 65 percent of the cost of health insurance for certain dislocated workers. Because the credit is refundable, individuals can claim the full benefit even if its value exceeds their income tax liabilities. To be eligible, individuals must be receiving either trade adjustment assistance or payments from the Pension Benefit Guaranty Corporation (which pays at least a portion of the pension benefit promised to retired workers if their company goes out of business or otherwise defaults on its obligations). The credit is not available to people receiving certain other government health benefits, including Medicare. In 2007, the tax expenditure for the credit was about $100 million.[7]

Options to Modify Tax Subsidies for Health Insurance

Tax subsidies could be redesigned in several ways to expand coverage. One option would be to replace the current exclusion of premiums for employment-based health insurance with a tax deduction or a tax credit. Another option would be to provide new subsidies to employers, in the form of tax credits, to encourage them to offer health insurance and to pay a portion of their employees' premiums. (Such an option could replace or supplement the current-law exclusion or be combined with new credits or deductions for individuals.)

Replacing the Exclusion with a Tax Deduction or a Tax Credit. The exclusion of premiums for employment-based insurance could be replaced with a deduction or a tax credit that is designed to encourage coverage. In addition, eligibility for those tax deductions or credits could be extended to all taxpayers who purchase health insur-

7. The estimate of the tax expenditure includes the amounts (or outlays) paid to taxpayers in excess of their income tax liability, which result from the refundable nature of the health coverage tax credit.

about 6 million in the number of workers offered coverage, roughly half of whom would have been uninsured before receiving the new offer.[19]

Changes in Employees' Other Insurance Options. Employers' decisions about offering coverage are also affected by changes in the relative attractiveness of their employees' other insurance options, such as individually purchased plans or Medicaid coverage. For example, legislation that expanded eligibility for Medicaid could make some of a firm's employees (or their dependents) eligible for that program; alternatively, a proposal could provide a new tax credit for policies that are purchased in the individual market. Other factors held equal, a firm would be less likely to offer coverage if the relative attractiveness of its employees' other options increased.[20] The magnitude of that effect is estimated to be roughly one-third as large as the direct effect of changes in the price of employment-based insurance; that is, a proposal that provided a 10 percent subsidy for policies purchased in the individual insurance market would have about the same effect on employers' offers as a proposal that increased the net price of insurance purchased through an employer by 3 percent to 4 percent. (Both proposals would increase the *relative* attractiveness of individually purchased insurance.)

In addition to a firm's size, the other factors that would affect whether employers drop coverage include the average tax rate its employees face (lower rates mean that employees obtain less of a benefit from the current exclusion for employment-based insurance) and the relative value of the alternative insurance. Some firms that continue to offer coverage may also change the amount they contribute toward premiums in response to changes in the attractiveness of outside insurance options. On the basis of the limited evidence that is available, CBO estimates that firms would increase the share of the total premium employees pay by about 2 to 3 percentage points if the share of their workers eligible for Medicaid increased from 20 percent to 40 percent.[21]

19. CBO generally assumes a "linear" relationship between the change in the price of insurance and the elasticity of offer; that is, the elasticity of offer does not vary with the magnitude of the price change.

20. For a more extensive discussion, see Congressional Budget Office, *The State Children's Health Insurance Program*.

Individuals' Decisions to Enroll in an Insurance Plan

Individuals' decisions to enroll in a plan are affected by the price of insurance, their income, and the options available to them. In the private market, those options may include enrolling in an employment-based plan (if they work for a firm that offers insurance) and purchasing insurance in the individual market. Individuals' decisions to enroll in a private plan will also be affected by whether they are eligible to participate in a public program.

Purchasing Employment-Based Insurance. After firms make their decisions about offering and subsidizing insurance—reflecting the average effects of the policy proposal on their workers and the aggregate cost of insurance—workers choose whether to enroll and where to obtain their coverage. As with employers' decisions to offer health insurance, the choice to enroll in a plan will depend on the price of employment-based health insurance and alternative options. In this case, however, the key factor affecting enrollment rates is the premium that employees themselves pay, not the total cost to the employer and employee combined. Even though workers ultimately "pay" for employers' contributions toward their health insurance, primarily through reduced wages, studies have found that employees' decisions about enrollment are not sensitive to the amount the employer pays. That finding reflects the fact that once an individual has decided to work for an employer that offers insurance, it is generally infeasible for that worker to recoup the employer's contribution by declining coverage.

Several studies have attempted to estimate employees' responses to changes in the amount they have to pay for employment-based insurance by comparing the behavior of workers who face lower insurance premiums with that of workers who face higher premiums.[22] The results of

21. See Thomas Buchmueller and others, "The Effect of SCHIP Expansions on Health Insurance Decisions by Employers," *Inquiry*, vol. 42, no. 3 (2005), pp. 218–231; and M. Susan Marquis, "The Role of the Safety Net in Employer Health Benefit Decisions," *Medical Care Research and Review*, vol. 62, no. 4 (2005), pp. 435–457.

22. See Linda J. Blumberg, Jessica Banthin, and Len Nichols, "Worker Decisions to Purchase Health Insurance," *Journal of Health Care Finance and Economics*, vol. 1, nos. 3–4 (2001), pp. 305–325; and Jonathan Gruber and Ebonya Washington, "Subsidies to Employee Health Insurance Premiums and the Health Insurance Market," *Journal of Health Economics*, vol. 24, no. 2 (2005), pp. 253–276.

those studies can be illustrated by examining what would happen to enrollment in employment-based plans as the share of the premium that the employee pays is reduced from current levels to zero; for simplicity, the illustration focuses on the 149 million nonelderly individuals, including workers and their dependents, who work for employers that offer health insurance but who are not eligible for public coverage.

According to a survey of employers conducted by the Kaiser Family Foundation, employees' premiums currently average about 16 percent of the cost of single coverage and about 27 percent of the cost of family coverage, and at those subsidy rates approximately 137 million people are covered through an employment-based plan in 2009. Another 1 million choose to purchase insurance in the individual market. Of the 11 million who are not covered, CBO estimates that about 3 million would obtain coverage if their contribution was cut in half, and about 4 million more would do so if that contribution was reduced to zero. In other words, even if they were offered insurance for free, the remaining 4 million—or 3 percent of the individuals who could be covered through their employer—would decline that coverage and remain uninsured.

Those enrollment rates are average measures of the expected response by employees to a change in the price of insurance, but other factors would also play a role. For example, the probability of uninsured individuals' enrolling in their firm's plan is affected by their income and by the availability and attractiveness of other coverage options. Workers with higher income tend to have higher enrollment rates than those with lower income, although those rates would be expected to converge as subsidies approached 100 percent. By contrast, individuals with access to Medicaid or other public coverage or whose children have public coverage would be less likely to enroll in family coverage offered by an employer, and the likelihood would be reduced in proportion to the percentage of children covered by a public program.

Purchasing Insurance in the Individual Market. Proposals could seek to expand coverage through the individual insurance market—for example, by equalizing the tax treatment of employment-based and individually purchased coverage or by subsidizing individually purchased insurance through new tax credits and tax deductions. As with their choices regarding employment-based coverage, individuals' decisions about whether to purchase coverage in the individual market are affected by its price, their income, and the availability of other insurance options.

Estimates of the response to changes in the price of individually purchased insurance are most reliable if subsidy rates are low, because that situation is similar to current experience. The available studies suggest that a new 25 percent subsidy for individually purchased coverage would cause 2 percent to 6 percent of the uninsured population to buy that coverage. The academic literature is not very informative, however, when prices are close to zero (that is, when subsidies approach 100 percent), because that situation is currently not observed in the individual market. CBO therefore estimates the effects of high subsidies using evidence about participation rates in existing public programs (which are, in general, highly subsidized).

On the basis of that evidence, CBO estimates that people would gradually become more responsive to changes in the price of individually purchased insurance as subsidy rates increased; moreover, they would become increasingly likely to obtain coverage when subsidy rates exceeded 70 percent (see Figure 2-2). Of the roughly 45 million nonelderly individuals who do not work for employers that offer health insurance or who are not eligible for public coverage, about 20 percent are covered by an individually purchased policy in 2009; the current subsidy rate is close to zero. Adding a 25 percent subsidy for individually purchased coverage would increase the participation rate for that population by 3 percentage points, to 23 percent, CBO estimates, reducing the uninsured by about 1.4 million people. Increasing the subsidy rate to 50 percent would roughly double the impact, but increasing the participation rates above 50 percent would require the subsidy rate to exceed 80 percent (holding other factors equal). Such subsidies, moreover, would make insurance in the individual market more attractive relative to employment-based plans, causing some employers to decide not to offer coverage to their employees.

Impact of Eligibility for Public Programs. People who are eligible to participate in public programs, such as Medicaid and SCHIP, will also be affected by proposals that lower the costs of employment-based or individually purchased plans. Their response will be influenced by many of the same factors that affect the decisions of those who are not eligible for public programs to purchase health insurance in the private market—the price of health