Analyzing the Kerry and Bush Health Proposals: Estimates of Cost and Impact

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Introduction

The number of Americans without health insurance remains high. According to the latest Census Bureau figures, 45 million people were uninsured during 2003, an increase of almost 1.4 million from the year before.[1] About 15.6 percent of the population did not have health insurance last year. That is the highest rate of non-coverage since 1998, when 16.3 percent were uninsured.

The consequences of not having health insurance can be severe. Although assistance is available to many through public hospitals and community health centers, people without health insurance may delay necessary treatment out of concern about cost. That can lead to the use of more health services than might have been needed if the illness was addressed more immediately, higher cost to the health system, and worse outcomes for the patient.[2]

As part of their campaigns for the presidency, Senator John Kerry and President George W. Bush have proposed policies intended to reduce the cost of health care and increase the number of people with health insurance. This is the second of two reports from the American Enterprise Institute on the health plans of the presidential candidates. The first report addressed how the two plans would affect the uninsured and the incentives driving the rising cost of health care in the U.S.[3] This study presents an independent cost estimate and impact analysis of the major policies offered by the candidates to expand access to health insurance.

The health plans offered by Senator John Kerry and President George W. Bush adopt different strategies to help the uninsured gain health coverage. Senator Kerry would expand government health programs and subsidize employers to provide insurance to their employees, with lesser subsidies directly to individuals. He would make a major commitment of taxpayer funds to underwrite his program. President Bush would extend new tax credits to individuals, and he would promote the purchase of high-deductible insurance. His proposals represent a smaller expansion of federal spending.

The cost estimates reported here are based on descriptions of the Kerry and Bush health plans available in July 2004. Both candidates' plans have been modified since then, and we attempted to adjust our analysis to reflect those changes.

Over the ten-year period between 2006 and 2015, the Kerry plan would increase federal outlays by about $1.5 trillion (see Table 1). That estimate nets out the savings that could be obtained from several provisions included in the plan. Because much of the Kerry subsidy for private insurance would help reduce costs for people who already have

[1] Carmen DeNavas-Walt, Bernadette D. Proctor, and Robert J. Mills, *Income, Poverty, and Health Insurance Coverage in the United States: 2003,* U.S. Census Bureau, Current Population Report P60–226, August 2004.
[2] Committee on the Consequences of Uninsurance, Board on Health Care Services, Institute of Medicine, *Care Without Coverage: Too Little, Too Late,* National Academy Press, 2002.
[3] Joseph Antos, *Kerry, Bush, and the Uninsured,* AEI Health Policy Outlook, September–October 2004.

coverage, slightly more than $620 billion would directly benefit the uninsured. About 27.3 million people would be newly insured under the Kerry proposal.

Table 1. Comparison of Kerry and Bush Health Plans

	Kerry Plan	**Bush Plan**
Federal cost, 2006–2015	$1.5 trillion	$128.6 billion
Funding dedicated to the uninsured	$622 billion	$39.4 billion
Newly insured	27.3 million	6.7 million

Source: Authors' estimates.

The Bush plan would increase federal spending by almost $130 billion over that same ten-year period. His proposals would provide direct subsidies of almost $40 billion for the uninsured. About 6.7 million people would be newly insured under the Bush proposal.

We also compared our estimate of the Kerry plan with the estimate produced by Kenneth Thorpe and widely used by the Kerry campaign.[4] We find that the cost of the plan is $867 billion higher than the Thorpe estimate. There are two reasons. First, the Thorpe estimate tracks nine years of costs, rather than the full budget window facing the next president. Second, we believe that the cost increases of the spending proposals were underestimated, and the cost decreases from the saving proposals were overestimated.

Table 2. Comparison of AEI and Thorpe Estimates of Kerry Proposal

	AEI	**Thorpe**
	(2006–2015)	(2006–2014)
Federal cost	$1.5 trillion	$653 billion
Newly insured	27.3 million	26.7 million

Source: Authors' estimates and Thorpe, "Federal Costs and Savings Associated with Senator Kerry's Health Care Plan," August 2, 2004.

[4] Kenneth E. Thorpe, "Federal Costs and Savings Associated with Senator Kerry's Health Care Plan," August 2, 2004, available at http://www.sph.emory.edu/hpm/thorpe/kerry8-23-04.pdf.

Cost Estimate of Senator Kerry's Health Plan

Senator Kerry proposes to expand eligibility for Medicaid and the State Children's Health Insurance Program (SCHIP) and provide subsidies for private insurance purchased through employers.[5] Employers would have to satisfy several new requirements to be eligible for those subsidies. Individuals and employers could participate in a new subsidized purchasing pool modeled after the federal employees' health program. In addition to those program expansions and new subsidies, the Kerry plan includes several proposals intended to offset some of the expansion in federal outlays.

Between 2006 and 2015, the Kerry plan would increase federal outlays by $1.5 trillion (see Table 3). About $620 billion would be spent directly to finance coverage for the uninsured. Some 27.3 million people would be newly insured under this plan. The details of the proposal and the estimate are explained in the following sections. Additional information about data sources, estimating methodology, and key assumptions are provided in the appendices to this report.

Medicaid and SCHIP Expansion

The Kerry plan would extend eligibility for state Medicaid and SCHIP programs to three groups of people:

- Uninsured children in families with incomes below 300 percent of the federal poverty level ($56,550 for a family of four in 2004),
- Uninsured working parents in families under 200 percent of poverty ($37,700 for a family of four), and
- Other uninsured adults below the poverty line ($12,490 for a couple).

In addition, the current five-year waiting period for eligibility of legal immigrant pregnant women and children would be removed and children with disabilities would be able to keep their health coverage when their parents return to work.

Under current law, the federal government pays an average of 57 percent of the cost of the Medicaid program, with states paying the other 43 percent of cost. Under Kerry's proposal, the federal government would "swap" some costs with the states. In exchange for states covering addition children and adults in SCHIP, the federal government would pay the full cost of all children in Medicaid.

[5] See "John Kerry's Plan To Make Health Care Affordable To Every American," available at http://www.johnkerry.com/issues/health_care/health_care.html. Our analysis is based on the version of this paper that was available in July but incorporates modifications that appeared in August.

Table 3. Kerry Health Plan: Estimated Cost to the Federal Government ($ Billions)

Changes in Outlays

	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2006–2015
Spending Provisions											
Medicaid and SCHIP											
Full fed. payment for Medicaid children	21.8	30.1	32.7	35.7	42.0	45.7	49.8	54.3	59.3	64.7	435.8
Insure children to 300% FPL (SCHIP)	2.5	9.4	12.8	13.8	15.8	17.0	18.2	19.6	21.1	22.6	152.9
Insure working parents to 200% FPL	3.6	10.4	14.1	15.3	16.6	18.0	19.3	20.8	22.3	22.3	162.8
Insure other adults to 100% FPL	0.0	4.5	9.7	13.1	14.2	15.4	16.6	17.9	19.2	19.2	129.6
Subtotal, Medicaid and SCHIP	27.9	54.3	69.3	77.9	88.7	96.1	103.9	112.6	121.8	128.8	881.1
Premium rebate	30.1	39.0	49.2	53.0	56.8	60.7	64.7	68.8	73.2	77.9	573.4
Premium subsidies[1]											
Small business	10.6	10.8	11.1	11.5	11.8	12.2	12.4	12.7	13.1	13.4	119.6
Individual	0.2	0.9	1.3	1.3	1.4	1.4	1.4	1.5	1.5	1.5	12.4
Premium limitation[1]	0.6	2.5	3.2	4.0	4.8	5.6	6.5	7.1	7.5	7.8	49.6
Subtotal, spending provisions	69.4	108.0	135.1	149.2	165.0	177.7	190.7	204.6	219.3	231.5	1,636.1
Saving Provisions											
Disease management	(a)	(a)	(a)	(a)	(a)	(a)	(a)	(a)	(a)	(a)	(a)
Health information technology	(a)	(a)	(a)	(a)	(a)	(a)	(a)	(a)	(a)	(a)	(a)
Reduce disproportionate share payments	-6.7	-7.9	-9.2	-9.5	-10.0	-10.4	-10.9	-11.4	-11.8	-12.2	-100.2
Reduce Medicare Advantage payments	-0.4	-1.7	-1.7	-1.7	-1.8	-1.9	-1.6	-1.8	-1.8	-1.8	-16.2
Subtotal, saving provisions	-7.1	-9.6	-10.9	-11.2	-11.8	-12.3	-12.5	-13.2	-13.6	-14.0	-116.4
Total	**62.3**	**98.4**	**124.2**	**138.0**	**153.2**	**165.4**	**178.2**	**191.4**	**205.7**	**217.5**	**1,519.7**

Memorandum

Change in state outlays, 2006–2015	-$263 billion
Federal outlays dedicated to the uninsured	$622 billion
Number of newly insured	27.3 million

Source: Authors' calculations.

1. Tax provision that reduces federal revenues.
(a) Less than $100 million.
Note: Numbers may not add due to rounding.

The Medicaid/SCHIP expansion would increase federal outlays by $881 billion between 2006 and 2015. About 18.5 million people would newly gain health coverage under this proposal, at a cost of about $550 billion. The remaining $331 billion represents additional federal outlays required under the "swap."[6] That money would pay the states' share of program cost for children who would already have been covered under Medicaid.

Federal assumption of all program costs of children enrolled in Medicaid would result in a substantial financial gain for the states. Since states would no longer have to share the cost of covering children in Medicaid, they will have a strong incentive to enroll as many uninsured children as possible in the program. Doing so would help ease financial pressure on local hospitals and other health providers at no cost to the state by reducing the amount of uncompensated care.

Some of those gains would be offset by increased state spending for additional children enrolled in SCHIP and newly-eligible adults enrolled in Medicaid and SCHIP. States would be required to pay a share of the program costs for those groups. The Kerry plan would provide an enhanced federal match for the adults, but states would still be required to pay some of the costs. Taking those offsets into account, states would realize savings of about $263 billion over the ten-year budget window.

Premium Rebate

The Kerry plan proposes several policies that would subsidize private health insurance. Under the premium rebate proposal, the federal government would reimburse employers for some of the costs incurred by catastrophically ill persons covered by the employer's health benefit plan. Employers would receive a subsidy equal to 75 percent of all medical costs incurred by the patient above a catastrophic spending threshold.

The threshold would be set to reduce the average cost of employer-sponsored health insurance by 10 percent. We estimate that the threshold would be about $36,000 in 2006 and would rise in later years with the growth in health spending. An employer with a work force in which no employee or dependent incurs more than $36,000 in health spending would receive no subsidy. An employer with one beneficiary incurring $40,000 in qualifying expenses in 2006 would receive a $3,000 premium rebate under the proposal—75 percent of $4,000.

Employers would have to meet three conditions to qualify for the premium rebate:

- Extend coverage to all employees,
- Adopt disease management and care coordination programs, and
- Pass the entire savings back to their employees.

[6] Of the $435.8 billion cost for 100 percent federal funding of children in Medicaid, $331 billion would be for children already enrolled and about $105 billion for individuals newly enrolled. See Appendix A for the details of the calculation.

The premium rebate would also be available to individuals participating in the Congressional Health Plan (a new insurance purchasing pool, discussed below).

The premium rebate is structured like commercial reinsurance, but the new subsidy does not add significantly to the financial protection against risk already available in the insurance market. Most small businesses offering a health benefit are fully insured. Medium-sized firms that are self-insured (and pay health costs directly) typically purchase stop-loss reinsurance similar to that offered by the Kerry proposal. Large employers have no need for reinsurance since they cover thousands of employees and have predictable aggregate health costs.

Although the premium rebate would have little effect on the stability of health insurance premiums, the subsidy would be attractive to many employers. This provision would increase federal outlays by about $573 billion between 2006 and 2015. About 1.8 million people would newly gain health coverage under this proposal, at a cost of about $8 billion. The remaining $565 billion represents payments provided to employers on behalf of people who already have health insurance.

We assume that most employers will participate in the premium rebate program. The barriers to entry are low. Most insurers already offer disease management programs as part of their usual plan offerings.[7] Proving that the subsidy flows through to employees may be more of a problem for the accountants than for the employers. The one potentially significant barrier is the requirement that employers extend their health benefits to *all* employees.

Contract workers and temporary employees are likely to be classified as independent contractors, not employees, and would not be offered coverage by the employer. Part-time employees would be offered coverage under the new mandate, but many will decline the offer because of low incomes or the availability of other coverage through a spouse or through Medicaid or SCHIP.

We assume that employers would be allowed to offer coverage on a pro rata basis, with their contribution reduced according to the number of hours the part-timer works. That substantially lowers the expected cost of the mandate, but does not diminish the amount of the subsidy. Since nearly half of all firms providing health benefits already

[7] Virtually all health plans offer disease management programs; see W. Pete Welch, Christopher Bergsten, Charles Cutler, Carmella Bocchino, and Richard I. Smith, "Disease Management Practices of Health Plans," *The American Journal of Managed Care*, Vol. 8, No. 4, April 2002. Three out of four employers sponsoring health plans report using disease management programs; see The Hay Group, *2004 Hay Benefits Report*, August 2004. Most individually purchased health insurance policies also incorporate disease management; see Thomas F. Wildsmith, *Individual Health Insurance: Wide Choice of Benefits Available*, AAHP-HIAA, February 2004. Recent data suggest the use of disease management, and other managed care techniques, is growing in response to recent increases in health care costs; see Glen P. Mays, Gary Claxton, and Justin White, "Managed Care Rebound? Recent Changes in Health Plans' Cost Containment Strategies," *Health Affairs* Web Exclusive, August 11, 2004.

offer that coverage to part-time employees, participation in the new subsidy program is likely to be high.[8]

Congressional Health Plan

The Kerry plan would create a new purchasing arrangement called the Congressional Health Plan (CHP), modeled after the Federal Employees Health Benefits Program (FEHBP). Under the proposal, insurers offering coverage to federal employees would be required to participate in CHP. Separate insurance pools would be established for FEHBP and CHP. Any individual or employer could choose to obtain health insurance through CHP.

Many of the specific implementation details for CHP remain unspecified. For example, although current FEHBP insurers would offer coverage under CHP, we do not know how broad the benefit might be. If CHP plans offer comprehensive coverage similar to what is available to federal employees, the total premium may be unaffordable to people with low income. As discussed below, the Kerry plan includes several subsidy provisions to help people buy coverage in CHP.

Assuming comprehensive benefits would be offered, premium rates in the first year are likely to be similar to rates offered under FEHBP. Those rates could be lower than rates in the non-group and small group market. That would give businesses and individuals an incentive to purchase coverage under CHP.

However, the CHP is a separate insurance pool and its rates would be determined solely by its own cost experience. It is unlikely that providing small employers with access to group purchasing through the CHP mechanism will significantly reduce the cost of coverage. State experience with purchasing pools has demonstrated that while such pools may increase the number of enrollment options available to the typical employee, they do not produce material reductions in premiums.[9] Thus, it seems unlikely that average costs in the small group pool within CHP would be significantly lower than the average for the existing small group market.

Premiums are likely to rise in succeeding years, causing the most favorable risks within the pool to drop out. This will lead to a new round of additional premium increases, causing the pool to shrink each year as groups with lower health spending leave CHP for lower-cost coverage elsewhere. FEHBP has not experienced ill effects from this "adverse selection" problem,[10] partly because the 75 percent premium subsidy

[8] The Henry J. Kaiser Family Foundation and Health Research & Educational Trust, *Employer Health Benefits: 2003*, September 2003.

[9] Elliot K. Wicks et al., *Barriers to Small-Group Purchasing Cooperatives*, Economic and Social Research Institute, March 2000; Stephen H. Long and M. Susan Marquis, "Have Small-Group Health Purchasing Alliances Increased Coverage?" *Health Affairs*, January–February 2001; Elliot K. Wicks, *Health Insurance Purchasing Cooperatives*, The Commonwealth Fund, November 2002.

[10] Curtis S. Florence and Kenneth E. Thorpe, "How Does the Employer Contribution for the Federal Employees Health Benefits Program Influence Plan Selection?" *Health Affairs*, March/April 2003: 211–218.

offered to federal employees virtually assures that they cannot get a better deal elsewhere. The new program would likely be more vulnerable since the subsidies (discussed below) are smaller.

We have not estimated a separate federal cost or saving for the CHP apart from the premium subsidies to individuals purchasing through the CHP. There could be an additional cost if subsidies were increased in later years to control the adverse selection problem.

Premium Subsidies

The Kerry plan proposes a number of additional subsidies for private insurance that are administered through the income tax system. Those proposals include:

- Refundable tax credits up to 50 percent of the premium for small businesses that contribute to the cost of their employees' health benefits,
- A 75 percent tax credit for unemployed workers when they are between jobs,
- Tax credits to individuals aged fifty-five to sixty-four, and
- Premium limitation, under which the self-employed and persons buying individual (non-group) insurance would receive a tax credit for premium costs that exceed 6 percent of their incomes.

Some of the details of those proposals were not specified in the Kerry health plan. To complete the cost estimate, we assumed that the small business provisions apply to firms with fewer than 50 employees. We also assumed that unemployed persons would receive a premium subsidy for up to six months, and that persons aged fifty-five to sixty-four would receive a 25 percent premium subsidy.

The combined effect of the four proposals on the federal budget is to reduce tax revenue by approximately $182 billion between 2006 and 2015. About 7 million people would newly gain health coverage under those provisions, at a cost of about $64 billion. The remaining $118 billion would subsidize those who already had insurance.

Saving Provisions

The Kerry plan also includes a variety of provisions intended to slow the growth of health spending and reduce the impact of his plan on the federal budget. Several of those proposals have been incorporated in the $653 billion cost estimate produced by Kenneth Thorpe.

Several of the candidate's most widely-discussed proposals were not included in the Thorpe analysis. Those provisions include government negotiation of pharmaceutical prices, requiring pricing disclosures by pharmacy benefits managers (PBMs), and certain limitations on medical liability cases. CBO has analyzed similar policies and concluded

that they would either have no significant effect on the federal budget or would increase federal outlays.[11]

To simplify this discussion, we confine our analysis to the four general saving provisions discussed in the earlier estimate. They are disease management (DM), health information technology (health IT), reductions in disproportionate share (DSH) payments, and reductions in payments to Medicare Advantage plans.

Disease management and health information technology are generally ascribed great potential for improving efficiency and reducing health care costs. Many policymakers and technical experts have endorsed both of those concepts, and both candidates have emphasized the need to promote their implementation. Insurers, health plans, and hospitals and other health care providers are moving aggressively to adopt DM and health IT. The federal government already has a variety of ongoing activities to encourage their adoption.

We examined the Kerry plan to identify proposals that would speed up the shift to DM and health IT, but no specific policies were listed that would accomplish that goal. Requiring that employer-sponsored health plans adopt DM programs would not significantly accelerate their implementation since most plans already offer DM.[12] Financial incentives to improve quality and invest in health IT might help, but no specific subsidies were offered in the plan and none were scored in the Thorpe estimate. Insurance claims are already processed electronically, and specific steps that the federal government could take to improve that processing were not listed.

We conclude that the Kerry plan would not accelerate the use of DM and health IT above the rapid rate of adoption that is expected to prevail over the next decade. Cost estimators refer to the budget savings that will automatically accrue without a change in policy as being "in the baseline." It appears that any DM and health IT savings are in the baseline.

The Thorpe estimate assumes that the federal government would cut Medicare payment rates to health care providers and health plans to capture savings from DM. We did not find such a policy listed in the Kerry plan, but payment cuts would yield scoreable savings if adopted.

Two other policies assumed in the Thorpe estimate are payment reductions that would yield scoreable savings. Disproportionate share payments are made through Medicare and Medicaid to hospitals that serve a high percentage of low-income patients. The Kerry plan indicates that his policies would reduce the cost of uncompensated care to

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[11] Letter from Douglas Holtz-Eakin to Sen. Wyden, Congressional Budget Office, March 3, 2004, available at www.cbo.gov/ftpdocs/51xx/doc5145/03-03-Wyden.pdf; Congressional Budget Office Cost Estimate of H.R. 1 and S. 1, July 2003, available at www.cbo.gov/ftpdocs/44xx/doc4438/hr1s1.pdf; Congressional Budget Office, *Limiting Tort Liability for Medical Malpractice*, January 2004, available at www.cbo.gov/ftpdocs/49xx/doc4968/01-08-MedicalMalpractice.pdf.

[12] Welch et al., "Disease Management Practices of Health Plans," op. cit.

the Federal government, and the Thorpe estimate assumes that those savings would be captured by reducing DSH payments.

Senator Kerry has also made clear that he would roll back some of the payment increases to Medicare Advantage (MA) plans that were legislated in December 2003 as part of the Medicare Modernization Act. MA plans are available as an alternative to traditional Medicare for beneficiaries living in certain parts of the country. The Thorpe estimate assumes that the stabilization fund created last year would be eliminated, and we follow this assumption.

Our estimate gives full credit for savings from reductions in DSH and MA payments. Although there is some ambiguity in the Kerry plan document, we believe that it does not endorse across-the-board reductions in Medicare payments as part of the strategy to promote disease management. Health IT savings are already in the baseline and would not be scored by CBO.

Comparison with Thorpe Estimate

We have estimated the cost of the major provisions affecting the uninsured in the Kerry health plan over 2006 to 2015. That time period coincides with the budget window that would face John Kerry next year, were he to become president. In contrast, the widely-cited cost estimate by Kenneth Thorpe represents a 2005 to 2014 budget window. Using that earlier window understates the budget impact of the Kerry plan.

A comparison of the two analyses reveals that we estimate substantially higher costs for the Medicaid and SCHIP expansions than does Thorpe (see Table 4). Note that the methods used in the two estimates differ, so line-by-line comparisons may be somewhat confusing. Looking at the bottom line, however, our estimate of the Medicaid and SCHIP expansions is more than $360 billion higher, reflecting both the addition of cost incurred in 2015 and a substantially higher estimate of the cost of the Kerry swap. The swap (which is included in the cost of full federal payment for Medicaid children in the table) would increase federal outlays by $331 billion over the full ten-year budget window. The Thorpe estimate assumes that the swap would cost $135 billion over nine years. Our nine-year estimate for the federal cost of the swap is $285 billion, still considerably higher than Thorpe's.

Table 4. Kerry Health Plan: Comparison of Cost Estimates ($ Billions)

	Changes in Outlays		
	AEI	AEI	Thorpe
	2006–2015	2006–2014	2006–2014
Spending Provisions			
Medicaid and SCHIP			
Full federal payment for Medicaid children	435.8	371.4	237.4
Insure children to 300% FPL (SCHIP)	152.9	130.2	69.4
Insure working parents to 200% FPL	162.8	140.4	128.7
Insure other adults to 100% FPL	129.6	110.5	82.5
Subtotal, Medicaid and SCHIP	881.1	752.5	518.0
Premium rebate	573.4	495.5	256.7
Premium subsidies[1]			
Small business	119.6	106.2	66.9
Individual	12.4	10.9	65.8
Premium limitation[1]	49.6	41.8	44.4
Subtotal, spending provisions	1,636.1	1,406.9	951.9
Saving Provisions			
Disease management	(a)	(a)	-116.5
Health information technology	(a)	(a)	-79.9
Reduce disproportionate share payments	-100.2	-88.0	-88.0
Reduce Medicare Advantage payments	-16.2	-14.4	-14.4
Subtotal, saving provisions	-116.4	-102.4	-298.8
Total	**1,519.7**	**1,304.5**	**653.1**
Memorandum			
Number of newly insured	27.3 million (AEI), 26.7 million (Thorpe)		

Source: Authors' calculations and Thorpe, "Federal Costs and Savings Associated with Senator Kerry's Health Plan," August 2, 2004.

1. Tax provision that reduces federal revenues.
(a) Less than $100 million.
Note: Numbers may not add due to rounding.

The estimates for other provisions are more directly comparable. We estimate significantly higher federal cost for the premium rebate and premium subsidies for small business. Our estimate for premium limitation is about the same as Thorpe's, and the premium subsidy for individuals comes in lower. We credit the Kerry plan with slightly higher savings on the payment reductions than does the Thorpe estimate.

The relevant budget window for the next president is 2006 to 2015. Eliminating the last year in that window reduces the cost estimate by about $200 billion. Even with that reduction, our estimate of the federal cost of the Kerry health plan comes to $1.3 trillion, well above the amount estimated by Thorpe.

Cost Estimate of President Bush's Health Plan

In his fiscal year 2005 budget, President Bush proposed to offer tax credits and other assistance to help individuals purchase private coverage.[13] A refundable tax credit would be made available to people with low incomes who do not have coverage through an employer or the government. A tax break was also proposed for individuals purchasing high deductible insurance. In addition, the Bush plan supported the creation of association health plans (AHPs) to make health insurance more accessible and affordable.

Those proposals were amended in a statement released by the White House on September 2, 2004.[14] The individual tax credit was modified to promote the purchase of high-deductible insurance with a health savings account (HSA), at the individual's option. A new tax credit was proposed for small business employees and the self-employed, also structured to promote HSAs. In addition, the Bush plan would allow individuals to purchase health insurance regulated under the rules of any state, rather than being restricted to insurance sold only in the person's state of residence.

Between 2006 and 2015, the Bush plan would increase federal outlays by almost $130 billion (see Table 5). About $40 billion would be spent directly to finance coverage for the uninsured. Some 6.7 million people would be newly insured under this plan. Additional information about data sources, estimating methodology, and key assumptions are provided in an appendix to this report.

Tax Credits and Deduction

The Bush plan would extend three new subsidies for the purchase of private insurance:

- Refundable tax credits for low-income people to purchase non-group coverage,
- Tax credits to small employers for their contribution to workers' HSA accounts, and
- Tax deductions for premiums paid for high-deductible health insurance.

The low-income tax credit would cover up to 90 percent of the cost of a non-group policy, and the maximum credit would be $1,000 for a single adult and $3,000 for a family.[15] The credit would be immediately available to those buying insurance, thus avoiding liquidity problems faced by a low-income population. The credit would be available to anyone meeting the income requirements who is not covered by an employer or government insurance program.

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[13] U.S. Treasury, *General Explanations of the Administration's Fiscal Year 2005 Revenue Proposals*, February 2004: 21–26, available at http://www.treas.gov/offices/tax-policy/library/bluebk04.pdf.
[14] The White House, *Making Health Care More Affordable*, September 2, 2004, available at http://www.whitehouse.gov/news/releases/2004/09/20040902.html.
[15] The maximum credit would be $1,000 per adult and $500 per child up to the family maximum of $3,000.

Table 5. Bush Health Plan: Estimated Cost to the Federal Government ($ Billions)
Changes in Outlays

	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2006–2015
Spending Provisions											
Low-income tax credit[1]	0.6	7.0	7.5	8.2	8.6	9.1	9.5	10.0	10.5	10.9	82.0
Small employer tax credit[1]	0.2	1.8	1.9	2.0	2.1	2.2	2.4	2.5	2.7	2.8	20.5
Above-the-line deduction[1]	0.8	1.0	1.1	1.3	1.6	2.0	2.5	3.1	3.8	4.8	22.1
Insurance market reforms											
AHPs	(a)	(a)	(a)	(a)	(a)	(a)	(a)	(a)	(a)	(a)	(a)
Grants to states	1.0	1.0	1.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	4.0
Broaden individual purchasing	(a)	(a)	(a)	(a)	(a)	(a)	(a)	(a)	(a)	(a)	(a)
Total	**2.6**	**10.8**	**11.5**	**12.5**	**12.3**	**13.3**	**14.4**	**15.6**	**17.0**	**18.5**	**128.6**

Memorandum

Federal outlays dedicated to the uninsured	$39.4 billion
Number of newly insured	6.7 million

Source: Authors' calculations.

1. Tax provision that reduces federal revenues.
(a) Less than $100 million.
Note: Numbers may not add due to rounding.

The full credit would be available to single individuals with incomes up to $15,000, and phases out completely at $30,000 income. For families, the credit phases out between $25,000 and $40,000 (for families with one adult) or $60,000 (for families with two adults). The credit could be used to subsidize insurance premiums or split between premiums and a payment into an HSA. An eligible family choosing a high-deductible insurance policy could use up to $1,000 of the credit as a contribution to their HSA.

The Bush plan would also offer a tax credit to encourage small employers to set up HSAs. Small employers who contribute to an employee's HSA would receive a credit of $500 for a worker with family coverage and $200 for a worker with individual coverage. The same credit would be available to self-employed individuals.

In addition, the plan would allow an above-the-line deduction for individuals purchasing a major medical policy in conjunction with an HSA. Such a deduction is available to individuals who do not itemize their deductions on their tax returns. A qualified health plan must have a deductible of at least $1,000 for single coverage or $2,500 for a family policy.

Taken together, the three subsidy proposals would reduce tax revenue by about $125 billion between 2006 and 2015. About 5.7 million people would newly gain health coverage with the two tax credits at a cost of about $37 billion. The remaining $88 billion would subsidize those who already have insurance.

Insurance Market Reforms

The Bush proposal includes three provisions to reform the health insurance market:

- Association health plans,
- Grants to states to create insurance purchasing pools, and
- Permitting purchasers of individual coverage to buy insurance regulated in any state.

AHPs would allow small businesses and associations to combine into a larger purchasing pool that could negotiate more favorable rates with health insurers. Similar to the treatment of large employers under ERISA-covered plans, AHPs would be exempt from state benefit mandates and premium regulation but would be subject to federal regulation.

The Bush plan would also grant $4 billion to states to create insurance purchasing pools. Such pools would also help reduce premiums through group purchasing, and could help additional people obtain coverage. About half of those funds would be spent on behalf of the uninsured, with the remainder benefiting people who already had coverage.

The provision to allow people to buy individual policies across state lines is intended to promote competition among insurance regulators and state legislators to reduce unneeded mandates that add to the cost of coverage. The impact of this provision on the federal budget would be minimal.

The three insurance reform provisions would have a combined cost to the federal government of just over $4 billion. About one million people would be newly insured under these proposals.

Appendix A
Kerry Health Plan: Medicaid and SCHIP Expansions

The Kerry health plan proposes to expand eligibility for Medicaid and SCHIP for uninsured children in families with incomes below 300 percent of the federal poverty level, uninsured working parents with incomes below 200 percent of poverty, and other uninsured adults with incomes below the poverty level. The federal government would assume the states' share of costs for all children enrolled in Medicaid in exchange for broader state coverage of children and adults under SCHIP. The federal government would also pay an enhanced matching rate for newly-eligible adults.

The methods used to estimate the cost of those provisions are described in this Appendix. To clarify the analysis, we present an example of the calculations necessary to estimate federal cost of the Medicaid and SCHIP provisions in 2010. Some of the details of the Kerry proposals, such as phase-in periods and federal payment rates, have not been specified by the campaign. We made plausible assumptions about those parameters to complete the estimate.

Full Federal Payment for Children Enrolled in Medicaid

Currently, states and the federal government split the cost of Medicaid according to the Federal Medical Assistance Percentage (FMAP) published each year. On average, federal outlays account for 57 percent of Medicaid cost. Under the Kerry plan, the federal government would cover the full cost of those children.[16] In addition, the current five-year waiting period for eligibility for legal immigrant pregnant women and children would be removed and children with disabilities would be able to keep their health care coverage when their parents return to work.[17]

CBO projects that 24.9 million children will be enrolled in Medicaid in 2010 for a federal cost of about $42.4 billion.[18] That translates into a per capita federal cost of approximately $1,696, which represents 57 percent of the total cost. The state portion of the cost per capita is approximately $1,279. Together, the total cost of a Medicaid child in 2010 is $2,975. In the aggregate, the federal assumption of the states' cost for children enrolled in Medicaid—known as the Kerry swap—would increase outlays in 2010 by approximately $33.6 billion, including the cost of benefits and administration (see Table A.1). Over 10 years, the federal cost of the swap comes to about $331 billion.

Federal outlays would also increase for immigrants, the working disabled, and children of working parents. Those groups represent about 2.7 million people, according to the most recent data from the Medicaid Statistical Information System. If the federal

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[16] "John Kerry's plan would assure that the Federal government picked up the cost of the nearly 20 million kids enrolled in Medicaid in exchange for states covering kids in the Children's Health Insurance Program," from *John Kerry's Plan To Make Health Care Affordable To Every American*, available at http://www.johnkerry.com/issues/health_care/health_care.html.

[17] This is a direct quote from *John Kerry's Plan*, op. cit.

[18] Congressional Budget Office, "Fact Sheet for CBO's March 2004 Baseline: Medicaid and the State Children's Health Insurance Program," available at http://www.cbo.gov/factsheets/2004b/Medicaid.pdf.

government also picked up 100 percent of the expense for this group, outlays would increase by about $8.4 billion in 2010.

We estimate that the federal cost of benefits for Medicaid children would be $42.0 billion in 2010. The total federal cost of covering Medicaid children would be $435.8 billion between 2006 and 2015, including the swap and dropping the waiting period for eligibility.

Table A.1: Full Federal Payment for Children Enrolled in Medicaid, 2010

	2010	Source
1. Medicaid children	24.9 million	CBO baseline
2. Federal outlays	$42.4 billion	CBO baseline
3. Per capita cost, federal share (57% of total) (line 2/line 1)	$1,696	Calculation
4. Per capita cost, state share (43% of total)	$1,279	Calculation
5. Total per capita cost (line 3 + line 4)	$2,975	Calculation
6. Additional federal cost (line 1 * line 4 + 5.2% admin)	$33.6 billion	Calculation
7. Additional coverage of immigrants, working disabled, and children of working parents	2.7 million	MSIS
8. Additional federal cost (line 7 * line 5 + 5.2% admin)	$8.4 billion	Calculation
9. Total additional federal cost (line 6 + line 8)	$42.0 billion	Calculation

Coverage of Uninsured Children under 300 Percent of Poverty

As part of the "swap" proposed by the Kerry health plan, states will be responsible for covering uninsured children up to 300 percent of poverty at their state FMAP level. According to the Economic Research Initiative on the Uninsured (ERIU) at the University of Michigan, there are 7.4 million uninsured children under 300 percent of the poverty level. Absent other adjustments, we assume that 75 percent of them, or 5.6 million additional children, enroll in SCHIP in 2010 (see Table A.2).

Some of those children would be eligible for Medicaid and would not add to state outlays. According to the Kaiser Family Foundation,[19] 71 percent of uninsured children are eligible for Medicaid. Consequently, 3.2 million children would shift to the Medicaid program. States would have to cover in SCHIP the additional 2.4 million children who fell between the 300 percent FPL limit and Medicaid eligibility.

The federal government pays an enhanced matching rate under SCHIP, averaging 68.4 percent of the total cost of services. Based on the total per capita health cost of Medicaid children from Table A.1, the federal government would be responsible for a per capita cost of $2,035 in 2010. Federal outlays would increase by $5.4 billion in 2010 for

[19] Henry J. Kaiser Family Foundation, Commission on Medicaid and the Uninsured, *The Medicaid Resource Book*, July 2002, p.10

the 2.4 million children who would be added to SCHIP. That figure includes the cost of benefits and administration. It also accounts for the fact that new programs typically attract more enrollees than expected—the so-called woodwork effect

The federal cost of the 3.2 million children who were added to Medicaid would be $10.5 billion in 2010. This assumes that the federal government would pay for 100 percent of incurred expenditures.

The expansion of coverage to children would increase total federal outlays by approximately $15.8 billion in 2010. Over the ten-year scoring window, we estimate that the total cost to the federal government to cover children up to 300 percent of poverty will be approximately $152.9 billion.

Table A.2: Insure Children under 300 Percent of Poverty, 2010

	2010	**Source**
1. Uninsured children under 300% of poverty	7.4 million	ERIU
2. Increased SCHIP enrollment prior to adjustments (75% * line 1)	5.6 million	Calculation
3. Children shifted to Medicaid (71% * line 2)	3.2 million	KFF
4. Children remaining in SCHIP (line 2 – line 3)	2.4 million	Calculation

Cost of additional SCHIP children	**2010**	**Source**
5. Total per capita cost (Table A.1, line 5)	$2,975	CBO baseline
6. Per capita cost, federal share (68.4% * line 5)	$2,035	Calculation
7. Additional federal cost (line 4 * line 6 + 5% woodwork effect + 5.2% admin)	$5.4 billion	Calculation

Cost of additional Medicaid children from SCHIP outreach	**2010**	**Source**
8. Total per capita cost (Table A.1, line 5)	$2,975	CBO baseline
9. Additional federal cost (line 3 * line 8 + 5% woodwork effect +5.2% admin)	$10.5 billion	Calculation
10. Total additional federal cost (line 7 + line 9)	$15.8 billion	Calculation

Note: Numbers may not add due to rounding.

Coverage of Working Parents under 200 Percent of Poverty

The Kerry proposal would expand coverage to working parents under 200 percent of poverty. The federal government would pay an enhanced matching rate for those additional program expenses.

According to the proposal, about 7 million working parents do not have health insurance. We based the cost estimate on baseline data from CBO showing projections of total federal expenditures and enrollment in Medicaid for non-disabled adults under age sixty-five. That allows us to calculate federal per capita cost for adults in 2010.

Since the federal match averages 57 percent of total spending, we also could calculate the total per capita cost including the state share.

The enhanced matching rate was not specified in the proposal. The SCHIP experience suggests that an average matching rate higher than 68.4 percent would be necessary to encourage states to aggressively expand coverage to adults. We assumed that the enhanced FMAP would be 90 percent. We also assumed that about 75 percent of eligible adults would enroll in the program.

Including the cost of benefits and administration plus a 5 percent woodwork effect, we estimate that the federal government would incur costs of approximately $16.6 billion in 2010 for uninsured, working adults. Over ten years, the federal government would pay approximately $162.8 billion.

Table A.3: Cover Uninsured Working Parents under 200 Percent of Poverty, 2010

	2010	Source
1. Uninsured working parents under 200% of poverty	7.4 million	Kerry plan
2. Non-disabled adults under 65 in Medicaid	14.1 million	CBO baseline
3. Federal outlays	$24.3 billion	CBO baseline
4. Per capita cost, federal share (57% of total) (line 3/line 2)	$1,723	Calculation
5. Per capita cost, state share (43% of total)	$1,301	Calculation
6. Total per capita cost (line 4 + line 5)	$3,024	Calculation
7. Additional federal per capita cost (90% * line 6)	$2,721	Calculation
8. Total additional federal cost (75% of line 1 * line 7 + 5% woodwork effect + 5.2% admin)	$16.6 billion	Calculation

Coverage of Other Uninsured Persons under 100 Percent of Poverty

The Kerry proposal would expand health insurance to single and childless adults with incomes below the poverty line. The proposal indicates that there are approximately six million adults who are uninsured and live below poverty.

The calculation is similar to that for expanding coverage to parents. Assuming an enhanced matching rate of 90 percent and a 75 percent take-up rate, the total cost to the federal government would be $14.2 billion in 2010. That figure includes benefits, administration, and the woodwork effect. Over the ten-year scoring window, the total cost to the federal government would be $129.6 billion.

The Kerry health plan indicates that this coverage expansion might be delayed until "states get back on course to a more secure financial footing." We did not know when that condition would be met, and assumed no delay in implementing the proposal. Federal cost would be reduced if the provision was delayed, but the number of newly-insured people would also be reduced until this policy took effect.

Table A.4: Cover Single and Childless Adults up to 100 Percent of Poverty, 2010

	2010	Source
1. Uninsured single, childless parents under 100% of poverty	6.3 million	Kerry plan
2. Total per capita cost (Table A.3, line 6)	$3,024	Calculation
3. Additional federal per capita cost (90% * line 2)	$2,721	Calculation
4. Total additional federal cost (75% of line 1 * line 3 + 5% woodwork effect + 5.2% admin)	$14.2 billion	Calculation

Appendix B
Kerry Health Plan: Premium Rebate

The Kerry health plan proposes a premium rebate that would subsidize the cost of health insurance claims in excess of a catastrophic cost threshold for employer health benefit plans that meet three conditions. Those employers must provide coverage for all their workers, adopt disease management and care coordination programs and pass the entire premium rebate to their employees. The premium rebate would also be available to individuals participating in the Congressional Health Plan.

The premium rebate subsidy would equal 75 percent of the cost incurred by a covered individual above the catastrophic threshold. The threshold would be set to reduce the average cost of employer-sponsored health insurance by 10 percent.

Methodology

The cost estimate depends on three elements:

- The level of the catastrophic threshold,
- The amount of spending above that level, and
- The extent of participation by employers and by individuals who buy insurance.

Data from the 2001 Medical Expenditure Panel Survey (MEPS) data were used to estimate the portion of claims above the catastrophic cost threshold. However, MEPS is a sample survey and understates the proportion of large claims. We used the Society of Actuaries (SOA) Large Claims Study to correct for this underestimate.[20] This correction produced an estimate that about 10 percent of health insurance claims will be in excess of $36,000 in 2006. That threshold would grow in later years.

To estimate the cost of those catastrophic claims, we applied this percentage to the Personal Health Expenditures portion of private insurance spending included in the National Health Expenditure (NHE) projections.[21] We excluded expenditures for nursing home, dental, and home health services, which are often covered in separate insurance policies not integrated with comprehensive private health insurance policies. We also excluded the cost of Medicare supplement plans from the calculation.

This method is likely to understate the cost of the premium rebate. It implicitly assumes that the distribution of health care claims does not change over time. Historical data show that the distribution of medical expenses by size has a long "tail" of very high cost claimants, which has grown steadily larger over time. In other words, as medical

[20] Kyle L. Grazier et al., *Group Medical Insurance Large Claims Database: Collection and Analysis*, SOA Monograph M-HB97-1, Society of Actuaries, August 1997.

[21] We used National Health Expenditure projections released February 2004. Those projections are based on the 2002 version of the National Health Expenditures, which were released January 2004. Data are available at http://www.cms.hhs.gov/statistics/nhe/default.asp.

technology has advanced, the proportion of medical spending attributable to severely ill individuals with catastrophic costs has increased.

Not all employers would choose to qualify for the premium rebate subsidy, and we would expect that take-up rates would be low initially as employers and others learn about the new program. We assumed 55 percent of employers would participate in 2006, 66 percent in 2007, and 77 percent in 2008 and thereafter.

Analysis of Participation Rates

How reasonable are those take-up rates? The major barrier to participation of employers is the requirement to cover all workers. Currently, many employers do not offer health benefits to contract workers, temporary employees, and part-timers. There is often a waiting period before permanent employees may participate in the employer's plan. The other requirements pose minimal difficulties. Disease and care management programs are already common in private insurance markets. The requirement to pass all the savings back to employees poses some administrative difficulties that are hard to gauge.

It is unlikely that coverage of contract workers and temporary employees would be an issue for employers under the Kerry proposal. Contract workers are unlikely to be affected, as they are not employees—or their contracts would be redrafted so that they would not be employees. We assume that temporary workers are also unlikely to be affected, as they are often contract workers and are unlikely in any case to enroll in a plan during a temporary assignment. Thus, the threshold for most employers will likely be their willingness to cover non-temporary, part-time workers, and new workers if there is a waiting period for coverage.

About 46 percent of firms that offer health benefits currently extend coverage to part-time employees.[22] Based on this offer rate, and coverage data by hours and weeks worked, we estimate the take-up rate among part-time workers offered coverage to be approximately 50 percent.[23] Part-time employees are less likely to accept health insurance offered by an employer for a number of reasons. Part-timers are often low-wage workers and may not be able to afford insurance unless they have another source of income. Some part-timers receive coverage as a dependent of a family member, and more part-time workers have employment-based coverage as dependents than have it in their own name. Some part-timers have coverage through Medicaid or SCHIP.

We interpret the coverage requirement to mean that employers must offer health benefits, but that they may prorate their contribution to the premiums on the basis of the

[22] The Henry J. Kaiser Family Foundation and Health Research & Educational Trust, *Employer Health Benefits: 2003*, September 2003.

[23] We estimate a 52 percent take-up rate among part-time workers who work all year and a 42 percent take-up rate among all part-time workers. Since many part-time workers who did not work a full year may be temporary workers, we assume the take-up rate for "permanent" part-time workers will be closer to the observed rate for full-year, part-time workers. Coverage statistics were taken from Paul Fronstin, *Sources of Health Insurance and Characteristics of the Uninsured: An Analysis of the March 2003 Current Population Survey*, Employee Benefit Research Institute, December 2003.

number of hours worked. Combined with a relatively low take-up rate by part-timers, it appears that offering coverage to a part-time worker will cost an employer considerably less on average than offering coverage to a full-time worker.

Given that 46 percent of employers already cover part-time workers, we believe that 50 percent is a reasonable lower bound on the percentage of privately insured Americans whose employer or health plan would participate in the premium rebate program. Our estimate calculations assume that, when the program is fully phased-in, a bit more than half the remaining employers and health plans would also choose to participate.

What impact does the program participation rate have? Adjusting the NHE projections as discussed above, we project that private health plans will pay $8.5 trillion dollars in medical claims for Americans under age 65 over the period from 2006 through 2015. If half the employers and health plans were to participate in the premium rebate pool, there would be $4.2 trillion in medical expenses paid by participating plans. A rebate covering 10 percent of these expenses would then cost $420 billion over the ten-year period. If two-thirds were to participate, there would be $5.6 trillion in total expenses for participating plans, and a 10 percent share would be $560 billion over the ten-year period. If three out of four participate, then benefit payments by participating plans would total $6.3 trillion over the ten-year period, and a 10 percent share would be $630 billion. While this calculation does not reflect the phase-in assumptions of the detailed cost estimate, it does suggest that the general magnitude of that estimate is appropriate and illustrates the direct relationship between the number of employers participating and the cost of the program.

In order to estimate the number of additional insured individuals that would result from the premium rebate, we obtained from MEPS a count of the current number of workers and their dependents who are currently uninsured whose employers offer health insurance coverage. First, we removed low-income individuals who would gain insurance under the Medicaid provisions in order to avoid double counting the number of newly insured. Consistent with our cost estimates, we next assumed that the percentage of employers offering coverage to part-time workers would increase from 46 percent to 77 percent, and that 52 percent of part-time employees newly offered coverage would accept the offer. The application of these percentages to the MEPS count produced an estimate of 1.8 million new workers covered by insurance. Because the premium rebate pool pays on average only 10 percent of the cost of coverage, the direct payments on behalf of these individuals would be quite low: $457 a year on average. However, newly insured individuals represent less than 5 percent of the employees on behalf of whom employers would claim a rebate—and less than 5 percent of the overall rebate spending.

Appendix C
Kerry Health Plan: Premium Subsidies

In addition to the premium rebate, the Kerry plan proposes a number of other subsidies for private insurance. Those additional subsidies would be administered through the income tax system. Small businesses would receive refundable tax credits of up to 50 percent of the premium for contributions to their employees' health benefits. Unemployed workers and individuals aged fifty-five to sixty-four would receive tax credits toward their purchase of health insurance. The self-employed and persons buying individual coverage would also receive a credit for premium costs in excess of 6 percent of their incomes.

Additional assumptions needed to complete the cost estimate are detailed below.

Small Business Provisions

Under the Kerry plan, small businesses would have access to the Congressional Health Plan (CHP) and the premium rebate pool. In addition, small businesses that contribute up to 50 percent of the cost of health insurance premiums would be eligible to receive payments of that amount from the federal government.

The federal government would administer such payments to businesses through their income tax returns. Businesses with a positive tax liability could offset that liability by the amount of the federal health insurance payments. Businesses with a net operating loss or that are currently not paying business income tax would receive the premium subsidy after filing their federal return.

For purposes of the estimate, the premium payments to business would apply to all small businesses regardless of their organizational form. (The Kerry plan did not define small business. We assume that small businesses are those with fewer than 50 employees.) The proposal would apply to corporations, S corporations, and partnerships. The proposal would not apply to businesses consisting of one person (sole proprietorships).

All small businesses would be able to claim their contributions to health insurance premiums through their tax returns. Small businesses currently offering insurance coverage and those seeking coverage for the first time could claim the premium payments through their tax returns.

It is also assumed that the portion of insurance premiums paid by the employer is not taxable to the employee, as under present law. Further, it is assumed that the employer does not receive a deduction for premium amounts reimbursed by the federal government. However, if an employer chose to contribute more than 50 percent of the premium, he could take a deduction for the additional amount not reimbursed by the federal government.

Individual Provisions

Uninsured persons who were either unemployed or nearing the age of Medicare eligibility would be eligible for premium assistance.

Subsidies for the unemployed. Unemployed persons would receive premium subsides equal to 75 percent of their premiums; we assume that the subsidy would be available for up to six months. There are no specified limitations on the types of plans for which the premium subsidy is provided nor any dollar limits.

The proposal does not appear to impose any income limitations that would restrict availability of the subsidy to the unemployed. However, the estimate assumes that premium assistance is available for primary health insurance coverage and available for a six month period. Further, an unemployed person would not be eligible for the credit if he receives coverage through a spouse or other family member's plan.

For purposes of the estimate, the unemployed individual must be registered with the state office of employment security as seeking employment, regardless of their eligibility for unemployment compensation.[24]

Subsidies for individuals aged fifty-five to sixty-four. Individuals aged fifty-five to sixty-four would also receive premium subsidies, although the Kerry plan does not specify the amount. We assume that the proposal would subsidize 25 percent of their premiums. As with the small business provisions, the Kerry plan administers such premium subsidies through the income tax system. The proposal does not limit how long individuals aged fifty-five to sixty-four may receive the subsidy.

We assume that premium assistance would be restricted to pre-Medicare-aged individuals with incomes up to 300 percent of the federal poverty guideline.[25] The federal poverty guideline for 2004 is $9,310 for an individual and $18,850 for a family of four.[26]

*Premium limitation***.** Under the Kerry plan, self-employed individuals and individuals purchasing non-group health insurance would have access to plans in the CHP and would receive premium assistance for certain costs. Individual purchasers with premium costs greater than 6 percent of income would receive payments for that excess from the federal government. The individual would report the excess premiums and claim the allowable payments for those excesses on his individual income tax return. If the individual has a positive tax liability, the excess premium payments would offset that liability. If the

[24] Eligibility for unemployment compensation is state specific, and many unemployed individuals no longer receive unemployment compensation but actively seek employment. The estimate assumes that the premium assistance would apply to all unemployed, not just the newly unemployed.

[25] See "The 2004 Campaign: Assessing the Merits and Costs of the Candidates' Domestic Agenda," June 23, 2004, the Brookings Institute.

[26] These estimates rely on the federal poverty guidelines, the poverty measures issued by Health and Human Services to determine eligibility for certain federal programs.

individual has no liability or anticipates a refund, the excess premium amounts would be payable to the individual (in addition to any refund).

The estimate assumes that income refers to adjusted gross income (AGI). We also assume that premium limitation would phase out for individuals with incomes between 150 and 300 percent of the federal poverty guidelines. Based on the 2004 guidelines, the premium limit would apply to individual taxpayers with incomes between $13,965 and $27,930 and for married taxpayers (with two dependents) with incomes between $28,275 and $56,550.

In addition, several sources indicate the plan would limit individual premium payments to between 6 and 12 percent of income. However, the details of how those percentages might apply are not available. The estimate assumes that the 6 percent of income limitation applies to all eligible taxpayers.

Basis of Cost Estimate

Data sources. Our estimates rely on several data sources, as a single data file does not contain the relevant information on health insurance coverage, employment status, and taxable income. The primary source of data for individuals is the Current Population Survey (CPS); for businesses, it is the Statistics of U.S. Businesses (SUSB).[27]

In order to prevent double counting those individuals who may receive coverage through an employer sponsored plan and those who may purchase their coverage directly, CPS data must be used to identify these two populations. The data must also account for those individuals who become newly eligible for public programs.

Despite calling the premium payments "tax credits," the payments have little to do with taxable income with one notable exception discussed later. The premium payments depend upon the type of policy purchased (individual or family coverage) and the corresponding amount of the premium. Since the CPS data report information on individuals, they must be converted to tax units.

Tax units reflect the tax filing rules in place for Tax Year 2003, for which CPS income is reported. An adjustment to the filing thresholds is made to approximate tax year 2003 filings. This is necessary to adjust for underreporting of certain types of income on the CPS and determine eligibility for the premium limit payment and eligibility for public programs. The premium limitation proposal that provides payments to individuals for premiums in excess of 6 percent of income is the only provision that relies on income defined by the income tax system.

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[27] The SUSB is an annual series that provides national and sub-national data on the distribution of economic data by size and industry. Statistics of U.S. Businesses covers most of the country's economic activity. The series excludes data on self-employed individuals, employees of private households, railroad employees, agricultural production employees, and most government employees.

Employer surveys and income tax data supplemented the primary Census data. Such surveys as the Kaiser Family Foundation Employer Benefits Survey, Watson Wyatt Survey of Employer Benefits, and Towers Perrin Employee Benefits and Retirement Survey provide insights into employer behavioral responses. Income tax data, used primarily to benchmark estimates from the Census files, are from the Internal Revenue Service Public Use Statistics of Income (SOI) files for both individual and business taxpayers.

Behavioral response. The behavioral response to the federal premium subsidies would affect take-up rates, or the rates at which currently uninsured businesses and individuals are willing to seek insurance coverage. Clearly there are many factors that influence the employer's decision to offer health benefits to employees. Such factors may include the age and health status of the workforce, the desire to retain certain key employees, or the firm's own profitability.

While all of these factors may influence the decision, the analysis must make a somewhat subjective judgment about take-up rates. The analysis attempts to minimize the subjective nature of this key behavioral response by evaluating the relative benefit of the various premium payments (i.e., to offer employer benefits or allow employees to purchase insurance directly) along with the profitability of the small business. Despite the generous nature of the premium payments, some businesses may decide not to offer an employer health benefit. Since individuals have access to the CHP plans, as well as the premium limitation payments, some employers may consider this an acceptable alternative to offering coverage themselves.

In general, it is safe to assume that small employers choosing to offer health benefits are likely to choose a 50/50 cost-sharing arrangement to maximize the amount of the federal subsidy provided. Assuming the employer does not have liquidity constraints that would affect his decision, there is no additional cost to establishing this arrangement. However, some employers may, indeed, face liquidity constraints that limit the amount of premiums for which they will assume responsibility. In these instances, the wage structure of the workforce may also influence the decision. Lower-wage employees may be less likely to assume a greater share of premiums and may choose not to participate in the plan.

With respect to individuals aged fifty-five to sixty-four and unemployed individuals, the likely behavioral response will depend upon two primary characteristics, age and income. Uninsured individuals aged fifty-five to sixty-four might be more likely to seek insurance since health costs tend to increase with a person's age. Uninsured unemployed individuals, on the other hand, might be less likely to purchase coverage if they face significant financial constraints. In addition, some unemployed individuals can purchase COBRA continuation coverage from their former employers.

Small Business Provisions Cost Estimate

The subsidy to small employers who already provide employee health benefits represents a windfall to them, and constitutes 65 percent of the total cost to the federal government. The subsidy is likely to encourage some employers to increase their contributions to 50 percent of the premium to capture the full amount of the subsidy. That would provide additional financial help to some employees. The subsidy would also provide an incentive for some employers who do not currently offer coverage to do so, accounting for the remaining 35 percent of federal cost.

Individual Provisions Cost Estimate

The three provisions were estimated separately.

Subsidies for the unemployed. The estimate for the uninsured-unemployed population relies on data from both the CPS and the SOI. The CPS provides tabulations of uninsured individuals who are currently unemployed. The SOI provides data on the income distribution of individuals receiving unemployment compensation during the tax year. In addition to these two sources, the estimate also relies on data characterizing the duration of unemployment spells from the Bureau of Labor Statistics. Together these sources create a profile of unemployed people by income and by duration of their unemployment.

Based on these sources, it was assumed that unemployed individuals without tax liabilities (approximately 24 percent of the unemployed) would be unlikely to purchase health insurance, despite the generous subsidy payment. Unemployed individuals with positive tax liability were more likely to consider such a purchase. The estimate assumes that the likelihood of a purchase would increase with income.

Subsidies for individuals aged fifty-five to sixty-four. The estimate for uninsured individuals aged fifty-five to sixty-four depends primarily upon CPS tabulations, supplemented with employment data from the decennial census. The estimate assumes that uninsured individuals in this age group would be more responsive to the premium subsidy, particularly if they are working or have incomes well above the poverty guidelines.

Premium limitation. Since this estimate assumes that this provision phases out for individuals with incomes between 150 and 300 percent of the federal poverty guidelines, it has a somewhat limited impact. The estimate assumes that the premium limit would apply primarily to those individuals already purchasing health insurance and would induce very few uninsured individuals to purchase such coverage. The primary reason is the timing of the premium subsidy payments. For lower-income individuals, and particularly those individuals with families, liquidity constraints are likely to affect the decision to purchase insurance. As the proposal stands, the lower-income individual or family must still pay the full premium amount and wait (until the following year) for the rebate amount.

This estimate did not assume any provisions for advancing through payroll the premium limit payments. The primary reason for not assuming such advances is the cumbersome nature of documenting insurance premium amounts and payments for the employer. Another reason is that advancing such payments would require considerable documentation and reconciliation at tax filing time. Therefore, without considering methods to lower directly the premium payments, the individual faces much the same decisions to purchase insurance as under the present market conditions.

Changes to the Number of Uninsured

Overall, the provisions that subsidize premium payments provide a substantial windfall to currently-insured individuals, both through their employers and directly to individuals. This analysis does not account for the uninsured population that might obtain coverage through the expansion of public programs.[28] The four provisions analyzed here are likely to generate coverage for approximately 7 million currently uninsured individuals.[29] About 35 percent of the cost of these provisions would go to those people, with the remainder accruing to people who already had health coverage.

[28] These estimates did not interact fully with the other cost saving provisions that had the potential to reduce premiums. Premiums were based on information from Heath Insurance Association of America, Kaiser Family Foundation, and eHealthInsurance.

[29] This estimate attempts to account for filing status for those individuals that claim the premium rebate through their tax returns. In other words, the number of individuals gaining coverage would be higher than the number of tax returns.

Appendix D
Bush Health Plan

The Bush health plan proposes tax credits to help low-income individuals purchase non-group insurance and tax credits to small employers who contribute to a worker's health savings account. The plan also offers above-the-line deductions for the premiums paid for major medical coverage when purchased in conjunction with an HSA. In addition, the plan would permit the establishment of association health plans, give grants to states that create new health insurance purchasing pools, and permit individuals to purchase non-group coverage from any state.

Tax Credits

The three tax credit provisions were estimated separately.

Low-income tax credit. The proposal for low-income tax credits is described in detail in supporting documents to the president's fiscal year 2005 budget[30] as modified by a recent White House fact sheet.[31] In general, the proposal offers either tax credits for the purchase of insurance or a combination of tax credits and contributions to Health Savings Accounts (HSA) for eligible individuals. The target population includes lower income individuals or families without employer-provided coverage and without access to public programs.

In order to determine current year eligibility, a measure of prior year modified adjusted gross income (AGI) would be necessary. Single individuals with modified AGI up to $15,000 are eligible for the full credit. The credit amount would phase out for single individuals with modified AGI in excess of $15,000. Married individuals filing jointly, with modified AGI up to $25,000 are also eligible for the full credit. The credit amount phases out for married individuals with modified AGI in excess of $25,000.

The proposal would offer a credit up to 90 percent of the private market premium, subject to a $1,000 maximum credit amount for single tax filers. Eligible single filers with dependents may take an additional credit up to $500 for each dependent insured under the policy. Married individuals filing jointly may take a credit equaling 90 percent of private market premiums up to $3,000 for a family of four or more.

The credit amount would be refundable, and eligible individuals could receive advance payments of the credit through their employer's payroll system.

Recent changes to the tax credit option expand the existing tax credit to include purchases of an HSA. The proposal would reallocate the $3,000 credit for married

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[30] U.S. Treasury, *General Explanations of the Administration's Fiscal Year 2005 Revenue Proposals,* February 2004: 21–24, available at http://www.treas.gov/offices/tax-policy/library/bluebk04.pdf.
[31] The White House, *Making Health Care More Affordable,* September 2, 2004, available at http://www.whitehouse.gov/news/releases/2004/09/20040902.html.

individuals filing jointly ($1,000 for single filers) between the cost of the premium and the HSA.

Married taxpayers could opt to receive $1,000 to put into their HSA. Each year that the married taxpayers remained eligible, the government would deposit another $1,000 into their HSA. The family would own the HSA and could retain the account despite changes in employment or earnings. In addition to the $1,000 contribution, the family would receive a $2,000 refundable tax credit toward the purchase of high-deductible insurance. The $2,000 would cover a significant portion of the premiums.

Single taxpayers could receive a $300 contribution to the HSA, as well as a refundable tax credit of $700 to cover a portion of the insurance premium. Eligible individuals could opt to receive advance credits by claiming such credits through their employer's payroll system.

Small business tax credit. The plan would offer credits administered through the business income tax system to employers who provide HSAs to their employees and make contributions to the employee's account. Self-employed individuals and small businesses with less than 100 employees would be eligible for a credit toward contributions to the employee's HSA. The credit represents a direct subsidy to the small employers offering HSAs to employees. The small business would receive $500 for family and $200 for individual contributions to the HSA. Businesses or self-employed individuals could claim such HSA account subsidies when filing their Federal income tax returns.

The proposal has been described in general terms thus far, leaving certain parameters of the design unspecified and requiring that we make several assumptions. The estimate assumes that credits would be available to small employers and self-employed individuals who currently provide HSA plans to their workers or who buy such plans themselves. We also assume that the account contributions are not indexed for inflation, so the amount would remain constant throughout the budget window. Further, the estimate assumes that no deduction would be allowed for account contributions received from the federal government. However, the employer would be entitled to all other deductions available under present law.

Above-the-line deduction. The Bush plan would also permit an above-the-line deduction for certain health insurance premiums. Qualifying insurance would be high-deductible policies purchased in conjunction with an HSA. The annual deductible must be at least $1,000 for single coverage and $2,500 for family coverage. The deduction is available only to individuals who are not covered by an employer or government insurance plan.

Cost estimates. Our estimates rely on the Current Population Survey (CPS) and several other data sources to obtain information about health insurance coverage, employment status, and taxable income. Since the CPS data report information on individuals, they must be converted to tax units. Tax units reflect the tax filing rules in place for Tax Year 2003, for which CPS income is reported. The primary sources of data for self-employed individuals and small businesses are the CPS and Statistics of U.S. Businesses.

Approximately 5.9 million uninsured individuals would receive coverage under these tax proposals. About 70 percent of the cost of this proposal accrues to individuals who already have coverage.

Insurance Market Reforms

The Bush proposal for AHPs is similar to recent legislative proposals that have been scored by the Congressional Budget Office.[32] AHPs would permit small firms and associations to combine their employee pools and negotiate better prices from insurers. They would be exempt from state benefits mandates and would be subject in only a limited way to regulations that restrict the setting of premiums.

CBO's analysis indicates that the net impact of AHPs on the federal budget would be well under $1 billion over ten years. Federal revenue would decrease as some taxable wage and salary income would be shifted to tax-excluded health benefits. The availability of lower cost coverage would also reduce federal Medicaid spending as some people shift to private insurance. That effect more than balances the increase in Medicaid spending caused when some individuals lose employer coverage. On balance, about 600,000 people would newly gain coverage under AHPs.

Another proposal would grant states $4 billion to establish health insurance purchasing pools. Some states already have high-risk pools that provide access to insurance for people who have been deemed uninsurable because of their medical condition. State experience with such pools has been disappointing,[33] but the new proposal is not explicitly limited to high-risk pools. We assume that about one-half of the $4 billion would be spent on behalf of newly-insured individuals.

The final insurance reform proposal would allow individuals to purchase non-group insurance from vendors in their own state or in any other state. The concept is to promote competition among state regulators and legislators, who might eliminate benefit mandates and other restrictions that increase the cost of coverage in the individual and small group market. This proposal would minimally affect the federal budget.

The new insurance buying arrangements do not offer an additional subsidy, and their impact on the cost of insurance would be fairly modest. We estimate that about one million people would newly gain coverage under these provisions.

[32] Congressional Budget Office, *Cost Estimate: H.R. 660, Small Business Health Fairness Act of 2003,* July 11, 2003.

[33] See, for example, Elliot K. Wicks, *Health Insurance Purchasing Cooperatives*, The Commonwealth Fund, November 2002; and Mark V. Pauly and Len M. Nichols, "The Nongroup Health Insurance Market: Short on Facts, Long on Opinions and Policy Disputes," *Health Affairs web exclusive*, October 23, 2002.

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