May 1, 2008

Honorable Ron Wyden
United States Senate
Washington, DC 20510

Honorable Robert F. Bennett
United States Senate
Washington, DC 20510

Dear Senators:

At your request, the staffs of our two organizations have collaborated on a preliminary analysis of a modified proposal for comprehensive health insurance based on S. 334, the "Healthy Americans Act," which you introduced last year. That modified proposal includes various clarifications and changes that you have indicated you would like to examine as part of the consideration of that bill. Attachment A summarizes our understanding of your modified proposal.

The staffs of the Congressional Budget Office (CBO) and the Joint Committee on Taxation (JCT) have worked closely together for the past several months to analyze your modified proposal; this collaboration reflects both the novelty of the undertaking and the intimate connection between the revenue and expenditure components of this proposal. We have summarized our conclusions in this joint letter; its purpose is to give you preliminary guidance regarding an approximate range of revenue and cost results that might be expected from your modified proposal. This joint letter does not constitute and should not be interpreted as a formal estimate of your proposal's budgetary impact, which—for the purposes of scoring under the Congressional Budget Act—would ultimately be provided by CBO and would incorporate revenue estimates prepared by the JCT staff.

The basic thrust of your modified proposal is to require individuals to purchase private health insurance and to establish state-run purchasing pools and a system of Federal premium collections and subsidies to facilitate those purchases. The system's premium collection and subsidy mechanisms would be based largely on income tax filings, and the required benefits would initially be based on the Blue Cross/Blue Shield standard plan offered to Federal workers in 2011 and then allowed to grow at the rate of growth of the economy. Although employers would have the option of continuing to offer coverage to their workers, nearly all

individuals who were not enrolled in Medicare would obtain their basic health insurance coverage through this new system. Most enrollees in Medicaid and all enrollees in the State Children's Health Insurance Program (SCHIP) would have their primary insurance coverage shifted to the new system.

Your proposal also would replace the current tax exclusion for employer-based health insurance premiums with a fixed income tax deduction for health insurance. (In addition, employers that had provided health insurance would be expected to "cash out" their workers—that is, to increase workers' wages by the average contribution that the employers would have made for their health plan.) The proposal also would require new tax payments from employers to the Federal government and further would seek to recapture the savings to state governments from reduced expenditures on Medicaid and SCHIP.

There are several important distinctions between the proposal we analyzed and S. 334 as it was introduced. For example, our analysis was limited to the operation of the new health insurance purchasing system and did not take into account most of S. 334's provisions regarding the Medicare program or other provisions that would not directly affect the new system. More fundamentally, the modified proposal would tie the premiums collected through the tax system—as well as the premium subsidies for lower-income households—to the cost of the least expensive health plan available in an area that provided required benefits, not to the average premium amount, as under S. 334. Furthermore, the value of the new tax deduction would not vary with the premium of the insurance policy that was actually purchased, and the schedule of employers' payment rates would range from 3 percent to 26 percent (rather than 2 percent to 25 percent) of the average premium. Attachment B describes in more detail the main differences between your modified proposal and S. 334.

The preliminary analysis reflected in this letter is subject to three important limitations. First, the staffs of both JCT and CBO are in the process of enhancing our capabilities to estimate the effects of comprehensive health care proposals. Improvements in our methodologies or more careful analysis of your modified proposal's provisions—particularly as you translate those concepts into formal legislative language—could change our assessment of its consequences.

Second, any formal budget estimate will reflect the macroeconomic assumptions and the baseline projections of current-law tax and spending policies in effect at the time it is issued. That baseline could differ materially from today's baseline.

Third, we focused our analysis on a single future year in which the proposed system would be fully implemented. For that purpose, we settled on 2014, the sixth year of the current 2009–2018 budget window. Under an assumption that the proposal is enacted in 2008, that timeline for full implementation seems to us to

be achievable but could be optimistic, as we expect that it would probably take until 2012 for the new system to begin operation, and several years after that for various phase-ins and behavioral adjustments to take place. The new system would involve temporary net budgetary costs in its initial years; we have not analyzed the magnitude of those early-year transition costs.

Overall, our preliminary analysis indicates that the proposal would be roughly budget-neutral in 2014. That is, our analysis suggests that your proposal would be essentially self-financing in the first year that it was fully implemented. That net result reflects large gross changes in Federal revenues and outlays that would roughly offset each other.

More specifically, under your proposal, most health insurance premiums that are now paid privately would flow through the Federal budget. As a result, total Federal outlays for health insurance premiums in 2014 would be on the order of $1.3 trillion to $1.4 trillion. Those costs would be approximately offset by revenues and savings from several sources: premium payments collected from individuals through their tax returns; revenue raised by replacing the current tax exclusion for health insurance with an income tax deduction; new tax payments by employers to the Federal government; Federal savings on Medicaid and SCHIP; and state maintenance-of-effort payments of their savings from Medicaid and SCHIP. Attachment C provides more information about the approximate magnitudes of those components.

For the years after 2014, we anticipate that the fiscal impact would improve gradually, so that the proposal would tend to become more than self-financing and thereby would reduce future budget deficits or increase future surpluses. That improvement would reflect two features of the proposal. First, the amount of the new health insurance deduction would grow at the rate of general price inflation and thus would increase more slowly than the value of the current tax exclusion. Second, the minimum value of covered benefits that all participating health plans had to provide would initially be set at the level of the Blue Cross/Blue Shield standard option offered to Federal workers in 2011 (we assume that the system's inaugural year would be 2012); but under your proposal that average value would from that point forward be indexed to growth in gross domestic product per capita rather than growth in health care costs. Because Federal premium subsidies would be based on the cost of providing that level of coverage, the cost of those subsidies would grow more slowly over time.

We hope this analysis is useful to you. Not surprisingly, a number of uncertainties arise in attempting to predict the effects of such large-scale changes to the current health insurance system. Although we have provided a range of results that reflect our current expectations about likely outcomes, actual experience—and the results of a formal cost estimate—could differ substantially in either direction. If you

have any questions about this analysis, please do not hesitate to contact us; the staff contacts are Pam Moomau and Nikole Flax for JCT at 226-7575 and Philip Ellis for CBO at 226-2666.

Sincerely,

Peter R. Orszag
Director
Congressional Budget Office

Edward D. Kleinbard
Chief of Staff
Joint Committee on Taxation

Attachments

Attachment A

Specifications of the Healthy Americans Private Insurance System

Overview of proposal

- Universal coverage - Under the proposal, all citizens and permanent residents (with only limited exceptions discussed below) are enrolled in a basic minimum benefits package within the Healthy Americans Private Insurance System (HAPI). Any enhanced coverage is purchased separately by direct payment by the individual to the insurer (or direct payment to a newly created "Health Help Agency" (HHA), described below, if the HHA performs this function).
- Tax structure - The proposal provides for employers and individuals to share the cost of the program and to provide a tax subsidy for the cost of health insurance to individuals. However, the amount of the tax on employers and individuals and the subsidy for individuals is divorced from their choices with respect to health care.
    a. Payment for minimum coverage - Universal coverage is partially enforced through a requirement that payment for the lowest-cost premium is part of an individual's tax liability, and withholding tables are adjusted to reflect this liability, except that certain low-income individuals are eligible for premium assistance.
    b. Standard health deduction - The proposal replaces the exclusion for employer-provided health benefits with a health care standard deduction, which is phased in for employees who are entitled to a reduced premium and phased out for higher-income individuals and families.
    c. New tax on employers - Under the proposal, employers pay a new tax equal to between 3 percent and 26 percent (depending on employer size and revenue per full-time employee) of the national average premium for the minimum benefits package for each employee enrolled in HAPI.
- Administration - Administration of the program is by new state-sponsored HHAs. States must establish these organizations, which will approve health plans, provide for enrollment in plans, and act as a conduit for premium payments from the Federal government to individual insurance carriers.
- Effective date - The proposal will be first effective in 2012.

Universal coverage

- Generally, all citizens and permanent residents are enrolled in a HAPI plan, with certain exceptions detailed below. A HAPI plan is required to provide at least a minimum benefits package benchmarked to the actuarial value of the Federal Employees Health Benefits (FEHB) Program standard benefit option BlueCross/Blue Shield plan for 2011, indexed for subsequent years by the per capita increase in gross domestic product (GDP), rather than medical cost growth. Exceptions are as follows:
    a. Enrollment is optional for individuals enrolled in the health system of the Department of Veterans Affairs (VA) or the Indian Health Service and for non-Medicare retirees enrolled in employer-based coverage who retire before HAPI begins operation. Those individuals may continue their enrollment in non-HAPI plans until death. Alternatively, those individuals can switch into a HAPI plan.
    b. Individuals enrolled in Medicare and the military health system (TRICARE) (other than VA enrollees) are ineligible for enrollment.
- Individuals enroll by choice during an open season, but the default is automatic enrollment in the lowest-cost plan (that is, the lowest-cost basic HAPI plan) if an individual fails to enroll.
- In the event that the lowest-cost plan in a given area does not have sufficient capacity to accommodate all automatically enrolled individuals, the next cheapest plan is required to accept those enrollees to the extent that the least expensive plan did not have room. This process will continue (moving up the list of bids) if more capacity is still needed to accommodate automatically enrolled individuals.

Premium submissions

- Plans may establish up to four different premiums for coverage: single individuals; married couples; married couples with children; and adult individuals with children.
- Otherwise, premiums may vary only to reflect geography and smoking status, as determined by state regulators—that is, premiums are community rated for each type of policy.
- Submissions must meet requirements for minimum loss ratios (the share of premiums paid out as covered benefits); however, no minimum has been specified.
- Plans submit bids to reflect the average costs of all HAPI enrollees; that is, the bids are standardized. Payments to the plans are risk-adjusted by the HHA to reflect differences in demographic factors or health status for each enrollee.

a. On a monthly basis, HHAs generally pay plans an amount based on their total premium bids (subject to risk adjustment); states cover the "float" on any discrepancies and settle up through a reconciliation process later.

- Plans do not have to provide a benefit with the same actuarial value as the requirement. That is, all of their submissions may provide for additional benefits, but they have to identify separately the costs of the required benefit level and the costs of added benefits.
- To maintain unified risk pools, plans' bids are standardized to reflect a representative sample of all HAPI enrollees in the state (including any enrollees included in the employer coverage option described below).

Premium payments and subsidies

- Universal coverage is partially enforced through the requirement that payment for the lowest-cost premium is part of an individual's tax liability, and withholding tables are adjusted to reflect this liability, except that certain low-income individuals are eligible for premium assistance.
- The payment of the premium for the lowest-cost plan (determined by the regional HHA as the average of the two lowest bids for basic HAPI plan coverage) is by payroll withholding (or payment on the individual's return) unless the individual is eligible for full premium relief or a reduced premium.

  a. No premium subsidy is available for individuals or families with income equal to or above 400 percent of the Federal poverty level (FPL).

  b. No premium is required for individual filers (not claimed as dependents) or joint filers with no income tax liability (and thus not required to file a Form 1040) or with income less than or equal to 100 percent of the FPL.

  c. A sliding premium subsidy amount applies for individuals or families with income between 100 percent and 400 percent of the FPL.

  d. Payment of the lowest-cost premium is required independently of enrollment.

  e. The premium for an individual or family is treated as a Federal tax liability. Thus, resources will be provided to ensure that enforcement and collection tools of the Internal Revenue Service are adequate for this task.

  f. For the basic package, health plans generally are paid only the premium for the lowest-cost plan from the HHA via payroll withholding (or payment on the return). In the case of the two lowest-cost plans for a region, such plans are paid their actual premium bids by the HHA for providing such coverage. Any additional costs for the

basic package above the premium for the lowest-cost plan must be paid by individuals outside of the tax system.

- Enhanced coverage may be purchased under the proposal by an individual by direct payment to the HHA or insurance carrier. Basic coverage that is more expensive than the premiums collected through the tax system also must be paid for by direct payment to the HHA or insurance carrier. The payment amount is the excess of the premium for the plan over the premium amount collected through the tax system.

Replacement of tax exclusion with a health care standard deduction

- The proposal provides for a health care standard deduction for each tax return. The deduction depends on the taxpayer's filing status and the number of dependent children.
  a. The amount of the health care standard deduction is not related to the amount of the individual or family health insurance premium or other health care costs. The deduction is indexed to the consumer price index.
  b. For purposes of the estimate, the dollar amounts of the maximum health care standard deduction in S. 334, indexed by the consumer price index, are being used. The maximum deduction amounts in the Senate bill for 2009 are as follows:
     i. Individual: $6,025.
     ii. Couple with no dependent children: $12,050.
     iii. Single individual with dependent children: $8,610 plus $1,000 for each additional dependent child (beyond the first child).
     iv. Couple with dependent children: $15,210 plus $1,000 for each additional dependent child (beyond the first child).
  c. The health care standard deduction reduces the filer's adjusted gross income and thus is available to taxpayers subject to the alternative minimum tax.
- The health care standard deduction phases in for low-income taxpayers who are entitled to a subsidized premium and phases out for higher-income taxpayers:
  a. The deduction is phased in for individuals and families with income between 100 percent and 400 percent of the FPL to reflect the phasing out of the premium payment subsidy. Thus, there is no deduction for individuals at or below 100 percent of the FPL.
  b. The deduction is phased out for individuals with adjusted gross incomes between $62,500 and $125,000 and for joint filers between $125,000 and $250,000 to limit the tax subsidy to a specified income

range. Thus, there is no deduction allowed for individuals with income at or above $125,000 ($250,000 for joint filers).

- The proposal provides that most of the present-law tax subsidy provisions for medical care costs generally are eliminated or significantly reduced for individuals covered by HAPI:

  a. The exclusion for employer-provided health coverage, including amounts in health flexible spending accounts under cafeteria plans and health reimbursement accounts, is eliminated except for the following:

     i. The exclusion is retained for health coverage for people who retire more than two years before enactment and for employees who, by collectively bargaining, are covered under a plan on January 1 following the second anniversary of enactment.

     ii. The exclusion continues for long-term care services (as defined in section 7702B(c)). A cafeteria plan is permitted to provide long-term care insurance as a qualified benefit.

  b. The deduction for health insurance costs for self-employed individuals under section 162(l) is limited to the same group for which the exclusion for employer-provided health coverage is retained. It also remains available for long-term care. The new employer tax payment is also deductible. Otherwise, the deduction under section 162(l) is eliminated.

  c. The deduction under section 213 for medical care costs above 7.5 percent of adjusted gross income is retained under the proposal only for taxpayers who are not covered by a HAPI plan.

  d. Beginning two years after the date of enactment, the exclusion of the value of employer-provided health coverage for purposes of employment taxes (under the FICA, FUTA, and RRTA statutes) is retained only to the extent that the exclusion for employer-provided health coverage is retained.[*] Thus, it is retained only for certain retirees and collectively bargained employees and for long-term care insurance.

- Certain tax subsidies for medical care costs are modified as follows:

  a. Health savings account (HSA) contributions are allowed only in the context of a high-deductible health plan that is actuarially equivalent to the minimum benefits package; that is, insurers contribute to the HSA the amount needed to give the plan the required actuarial value. Additional contributions by individuals are not tax-preferred. Otherwise, the proposal does not change the current tax treatment for HSAs.

---

[*] FICA = Federal Insurance Contributions Act; FUTA = Federal Unemployment Tax Act; RRTA = Railroad Retirement Tax Act.

b. The tax exemption under section 501(c)(9) for voluntary employees' beneficiary associations (VEBAs) established by the date of enactment is retained. The exclusion under section 106(a) continues to apply for employers' contributions to VEBAs to the extent that the contributions are needed to fund existing obligations to non-Medicare retirees or those who retire within two years of enactment. The current limits for the deduction for employers' contributions to VEBAs under section 419 continue to apply.

Employer tax payments

- Employers pay a tax equal to between 3 percent and 26 percent of the national average premium for the minimum benefits package for each employee (except those employees excluded from HAPI), depending on their firm size and amount of gross revenues per employee.
- The following chart shows the percentage of the national average premium used to calculate the new tax, calculated per full-time-equivalent (FTE) employee.

Revenue per FTE Employee	Fewer than 50 FTE Employees	Over 200 FTE Employees
0 to 20th percentile	3%	18%
21st to 40th percentile	5%	20%
41st to 60th percentile	7%	22%
61st to 80th percentile	9%	24%
81st and higher percentile	11%	26%

- The rate for employers with 50 to 200 FTE employees is determined on a sliding scale (increasing 0.1 percentage point for each additional FTE).
- The rate for state and local governmental employers is the rate for employers with revenue of 41st to 60th percentile per FTE employee (7 percent to 22 percent of the national average premium depending on the number of FTEs).
- During the first two years of the program, employers who currently offer health coverage do not owe this tax with respect to eligible individuals enrolled in their health plan.
- This tax payment is deductible by employers.

"Cash-out" provisions

- For a two-year transition period, all employers are required to "cash out" their health plans. The cash-out is an increase in wages that an employer is

required to pay to reflect the replacement of employer-provided health benefits.

- In general, the amount of the cash-out is equal to the average costs that the employer had paid for a given employee's insurance policy (so that all enrollees in the same health plan with the same type of policy receive the same amount).

Health Help Agencies

- States must establish HHAs, which are charged with administering the selection of health plans to serve in each area.
- The determination of lowest-cost plan is made by HHAs as follows:
  a. Annually, plans submit bids to the regional HHAs on the premium they will charge for the minimum benefits package.
  b. The average of the two lowest bids will set the maximum amount of the premium that is collected through the tax system for all enrollees in that area.
- Insurance companies are permitted to charge premiums for the additional cost for any more comprehensive benefits plans they offer. Insurance companies with premiums for basic coverage that are more expensive than the premiums collected through the tax system are also permitted to charge individuals (directly or via their employers) for the extra premium amounts.
- The HHAs also are responsible for enrolling people in the plans they choose during the annual open enrollment period.
  a. Employers with 10 or more employees are required to administer annual open enrollment for their employees and their dependents using materials supplied by the area HHA. The results are communicated to the HHAs, who are responsible for actually enrolling people in the plans they have selected.
  b. Alternatively, people can change coverage during open enrollment online or directly with the HHA.
  c. Premium revenues for the lowest-cost plan in the area are forwarded to the HHA, which is responsible for payments to individual insurance carriers based upon the health plans selected by individuals.
- For the first two years of operation, administrative costs for HHAs are paid by the Federal government; after that, insurers are assessed fees to cover HHAs' administrative costs (and will build those fees into their premium bids).

Employer coverage option

- Employers can arrange to have HAPI plans that are available only to their employees. Such employer-only plans are approved by and paid by HHAs in the same manner as other HAPI plans. Enrollees continue to pay the premium they owe (if any) for the lowest-cost plan through the tax system.
- This option is similar to the option under the Medicare drug benefit whereby prescription drug plans approved by the Centers for Medicare and Medicaid Services can be offered to an employer's retirees on an exclusive basis. The HAPI employer option does not include the additional option that exists in the drug benefit whereby employers provide the drug plan for their retirees and receive a subsidy payment from Medicare.
- In particular, the HAPI employer option does not allow for the establishment of separate risk pools for providing the basic benefits to each employer's workforce; all enrollees in the same health plan in the same state pay the same basic premium for basic coverage (varying only according to the type of policy purchased—single, married with dependents, etc.).

Subsidies for cost-sharing and additional benefits

- For individuals who are enrolled in Medicaid or SCHIP as well as a HAPI plan, Medicaid or SCHIP payments reduce their cost-sharing liabilities for services that are covered by the HAPI plan—either to Medicaid/SCHIP cost-sharing levels or by the amount of the Medicaid/SCHIP payment for such services, whichever is less.
- Similarly, services covered by Medicaid or SCHIP that are not covered by HAPI plans (including but not limited to long-term care services) are covered and reimbursed for such enrollees under current rules for Medicaid/SCHIP.
- Ongoing Medicaid and SCHIP costs continue to be shared between Federal and state governments, as under current law.

Effect on other Federal programs

- The FEHB Program is replaced by HAPI for active employees but continues for the existing stock of retirees (and those within two years of retirement upon enactment).
- As discussed above, Medicare is not changed by HAPI. However, Medicare payments to hospitals treating a disproportionate share (DSH) of low-income patients are eliminated under the proposal, as are 90 percent of Medicaid's DSH payments.

States maintenance-of-effort payments

- States must make maintenance-of-effort (MoE) payments to the program equal to the amount of the reduction in state Medicaid and SCHIP spending.
- A state's MoE payments include savings in state government spending for people who would have been eligible for Federally matched Medicaid and spending for noncustodial adults covered under Federal 1115 waivers (HAPI replaces Medicaid to the extent of coverage in the minimum benefits package).
- A state's MoE payments do not include savings to state-only programs covering other groups that happen to have been administered as a part of Medicaid.
- A state's MoE payments reduce the premium subsidies paid by Federal government.
- MoE payments are calculated in a manner that is similar to that for the "claw-back" payments under the Medicare drug benefit.
    a. State savings from having HAPI plans cover the costs of acute care services for Medicaid and SCHIP enrollees who are not also enrolled in Medicare will be estimated for an initial year (the year of or the year prior to enactment).
    b. In future years, that dollar amount will be indexed by the nominal growth in national health expenditures.
    c. Adjustments will also be needed to address changes in enrollment over time.
    d. The Federal government could enforce the MoE requirement by withholding the appropriate amount from its payment to an HHA for premium subsidies or by withholding other Medicaid payments.

Cash flows

Payor	Payee	Description
Individuals/employer payroll withholding (reduced payments/ withholding for individuals qualifying for assistance)	Federal government	Payment amount is the average premium for the lowest-cost basic HAPI plan in the taxpayer's region; treated as a Federal tax liability
Employers	Federal government	Tax based on number of FTEs, employer's revenue per employee, and average national premium for basic HAPI plan
Federal government	HHAs	Premiums for basic HAPI plan coverage; premium assistance for families that qualify (Federal payment reduced by state MoE payments); during transition period, payments for HHA administration
HHAs	Insurance companies	Premiums for basic HAPI plan (and additional premiums for enhanced coverage or more expensive basic coverage if HHA performs this function)
Individuals/employers	Insurance companies (or HHAs)	Premiums for enhanced coverage or more expensive basic coverage
Insurance companies	HHAs	After transition period, fees for payment of HHA administration expenses
State governments	HHAs	State MoE payment: For premium assistance for families that qualify; amount is equal to state's reduction in Medicaid spending on account of HAPI program

Attachment B

Key Differences Between the Current Proposal and S. 334

Some important distinctions exist between the proposal that we analyzed and S. 334 as it was introduced. For example, our analysis was limited to the operation of the new health insurance purchasing system and did not take into account most of the bill's provisions regarding the Medicare program or other provisions that would not directly affect the new system. Other prominent differences between the modified proposal and the original legislation, as well as key refinements and clarifications, include the following:

- The minimum value of covered benefits that all participating health plans had to provide would initially be set equal to the value of the Blue Cross/Blue Shield standard option offered to Federal employees in 2011; in future years, that average value would be indexed to the overall growth rate of gross domestic product per capita.

- The premiums collected through the tax system—and the premium subsidy for lower-income households—would be tied to the cost of the least expensive plan available in an area that provided the required benefits, not to the average premium amount. Individuals could choose a more expensive health plan or one with more extensive benefits, but amounts in excess of that lowest-cost premium would not be collected through the tax system or be liabilities of the Federal government.

- Individuals who were required to enroll in a health plan through the new system but who did not select a plan would be automatically enrolled in the lowest-cost plan offered to them. Individuals would be liable to pay the premium for that plan through their tax return (regardless of whether they had actively enrolled) but would not face an additional penalty for failing to choose a plan.

- Premium withholding through the Federal tax system would be accompanied by information-reporting requirements and administrative resources allocated to the Internal Revenue Service and other relevant Federal agencies.

- The new tax deduction would be a fixed amount per year and would not vary with the premium of the insurance policy actually purchased; the additional deduction per child would be $1,000 and would not apply to the first child in a household.

- The schedule of rates for the employer tax would range from 3 percent of the average premium for smaller employers to 26 percent for larger employers, rather than 2 percent to 25 percent.

- Employers who had provided health insurance would be expected to "cash out" their workers—that is, to increase their wages by the average contribution that the employers would have made to pay for their health insurance—but the requirement would be more flexible than was specified in S. 334.

- Employers could arrange for a health plan that served their workers exclusively—which could provide more extensive benefits financed by an additional, unsubsidized premium—but otherwise that health plan would be approved and reimbursed by the state-run oversight agency in the same manner as the plans made available to the general public. This option would be similar to one that exists for employers under the Medicare drug benefit and would not create a separate risk pool for the minimum package of benefits provided to those workers.

- For individuals enrolled in Medicaid or SCHIP as well as in a plan in the Healthy Americans Private Insurance System (HAPI), Medicaid or SCHIP payments would reduce their cost-sharing liabilities for services also covered by the HAPI plan—either to Medicaid/SCHIP cost-sharing levels or by the amount of the Medicaid/SCHIP payments for such services, whichever was less. Additional or alternative Federal subsidies to reduce cost-sharing liabilities would not be available.

- The maintenance-of-effort requirement placed on states would seek to capture all state savings on Medicaid and SCHIP resulting from the shift in enrollees' coverage; the methods of calculation, enforcement mechanisms, and indexing provisions would be similar to the "claw-back" provisions of the Medicare drug benefit.

Attachment C

Approximate Magnitudes of Major Revenue and Outlay Components

As indicated in this letter, our preliminary analysis indicates that the health insurance proposal you asked us to analyze would achieve a rough balance between additional Federal outlays and additional Federal revenues in 2014. The net impact of this proposal reflects the largely offsetting effects of much larger gross changes in Federal revenues and outlays in that year, as follows:

- Most health insurance premiums that are now paid privately would flow through the Federal budget, and total Federal outlays for health insurance premiums would be on the order of $1.3 trillion to $1.4 trillion in 2014. Assuming outlays were in the middle of that range, individuals would pay from $650 billion to $800 billion through their tax returns, so the net Federal cost of premium payments would be in the range of $550 billion to $700 billion.

- Eliminating the current tax exclusion for health insurance premiums (as well as certain other health-related tax preferences) would raise Federal revenues, as would the new tax payments from employers, but instituting the new health insurance tax deduction would reduce revenues. The net effect of those three steps would be to increase Federal revenues in 2014 by an amount that would range between $400 billion and $500 billion.

- In our preliminary modeling, the factors that would cause net Federal premium payments to be higher would also reduce the cost of the new tax deduction in largely offsetting ways—narrowing somewhat our overall range of uncertainty. Thus, the combined effect on the budget of the provisions for premium payments, collections, and subsidies and the various changes in tax law described above would be to raise outlays more than they raised revenues by an amount ranging from $150 billion to $200 billion in 2014.

- Shifting Medicaid and SCHIP enrollees into separately financed private health plans would reduce Federal and state costs for those programs; depending on how effectively the maintenance-of-effort provisions for states were enforced, those savings would be between $150 billion and $200 billion in 2014 (figures that also reflect Federal administrative costs for the new system as well as the elimination of Medicare's "disproportionate share" payments to hospitals). Thus, the proposal would yield a rough balance between the net increases in outlays and the net increases in revenues in that year.