Forecasting the Effects of the Mitchell Health Bill

by

Gary Robbins

and

Aldona Robbins

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National Center for Policy Analysis
12655 North Central Expressway, Suite 720
Dallas, Texas 75243
(214) 386-6272

Executive Summary

The health reform plan proposed by Senator George Mitchell (D-ME) attempts to increase the number of people with health insurance by offering generous subsidies to induce voluntary compliance. Employer mandates would kick in only if the fraction of people with insurance failed to reach 95 percent in a state by the end of the decade. Reaching that goal is unlikely, however. The reason is that the Mitchell bill would allow people to purchase insurance at community-rated premiums after they get sick — thus encouraging them to go uninsured until an illness occurs.

Subsidies for lower-income families under the Mitchell bill would total more than a trillion dollars over the next ten years. The cost would fall mainly on the middle class and most of it would be hidden. *For every $1 in direct taxes, there are at least $2 and possibly as much as $4 in hidden costs.*

- By the year 2003, as much as $114 billion of annual costs would be shifted to people with private insurance because the Mitchell bill would put the Medicaid population in private health plans and pay premiums well below the expected cost of their care.
- Another $54 billion per year in costs would be shifted to private patients because of underpayment for doctor and hospital services by Medicare.
- If more people became insured under the Mitchell bill, there would be less cost shifting from uninsured patients who can't pay their medical bills, but this gain would be more than offset by the increased cost shifting from Medicare and Medicaid.
- Overall, we estimate that the cost of the Mitchell bill for middle-class families in the year 2003 would be at least $121 billion and possibly as much as $200 billion.
- That means that the average household could face a burden of almost $2,000 per year.

Some health economists believe that as the medical marketplace becomes more competitive, doctors, hospitals and other providers will find it impossible to shift costs from patients who underpay to other patients. If so, patients whose insurer refuses to pay the full cost of normal services will receive inferior services and possibly rationed care.

That eventuality would not hurt Medicaid patients since under the Mitchell bill they would join private health plans and would be able to see the same doctors and enter the same hospitals as private patients. The elderly, however, may face a two-tiered health care system under which they would be denied access to many physicians and facilities.

- Under the Mitchell bill, underpayment of medical expenses by Medicare would more than triple — growing from $44 billion this year to $162 billion by the year 2003.
- As a result, almost one out of every three health services for the elderly in 2003 would have to be either rationed or paid for by shifting costs to other patients.

To assess the impact of the Mitchell plan on the economy, we used the National Center for Policy Analysis/Fiscal Associates Health Care Model to produce the following dynamic forecast:

- Health care spending would increase — adding at least $81 billion or about $800 per household to the nation's annual health care bill within five years.
- Attempting to meet the demand for more health care services would cause the economy to pay an increasingly higher price — and to lose more than $100 billion per year in other goods and services by the end of the decade.
- The inefficiencies caused by attempting to expand health care output combined with the impact of higher taxes and work-discouraging subsidies would harm the economy as a whole and lead to 918,000 fewer jobs by the year 2002.
- Despite the higher taxes, costs to the federal government would exceed revenues, producing deficit spending that would accumulate to $150 billion over the next decade.

How does the Mitchell bill compare to the original Clinton health reform plan? Initially, Mitchell avoids employer mandates and imposes significantly lower taxes. Yet the Mitchell bill would have a much more negative impact on the labor market. This is because the Mitchell subsidies are withdrawn as family income rises in a way that creates 80 percent to 90 percent effective marginal tax rates for some people. Overall:

- Under the Clinton plan, job losses peak at 783,000 in the year 2000 and then ameliorate, reaching 473,000 lost jobs by the year 2005.
- Under the Mitchell plan, job losses peak at 918,000 in the year 2002 and are still as high as 861,000 in the year 2005 — almost twice the total of lost jobs that year under the Clinton plan.

Since these estimates are conservative, job losses under both plans could be much higher.

Introduction:

Major Features of the Mitchell Health Plan

Senate Majority Leader George Mitchell has proposed a plan to reform the U.S. health care system. The purpose of this study is to forecast the effect the reform would have on the average family, the health care sector and the economy as a whole. As we prepared this study, Senator Mitchell was making important changes in his plan. However, by identifying and quantifying the plan's underlying problems, we hope to provide policymakers with information that is useful to their deliberations.

Subsidies First. Initially, the Mitchell proposal aims to increase health insurance coverage without mandates — primarily by offering subsidies to induce people (and in some cases their employers) to purchase insurance voluntarily. However, if 95 percent of the population in any state is not covered by January 1, 2000, coverage would be mandatory in the year 2002. Despite substantial subsidies, no state is likely to achieve this goal. The average coverage nationwide is 85 percent and trending downward. Even Hawaii, with a long-standing employer mandate, has only 93 percent coverage.[1] Moreover, the bill would impose regulations on the sale of health insurance that might actually increase the number of uninsured. [See the discussion below.]

"Despite substantial subsidies, no state is likely to achieve the goal of 95 percent coverage."

Mandated Health Insurance Second. The mandate would require employers with 25 or more employees to pay 50 percent of the health insurance costs for their employees. Employees would be required to pay the other 50 percent, and those with no employer would be required to pay 100 percent. Lower-income individuals would be eligible for subsidies so their health insurance costs would be no higher than 8 percent of income. People at or below the poverty level would pay no more than 4 percent of income. That limit would increase with income, reaching 8 percent of income at 200 percent of poverty.

Standard Benefit Package. The Mitchell bill would establish a standard package of health insurance benefits. The package would be formulated by a new federal bureaucracy called the National Health Benefits Board, similar to the National Health Board in President Clinton's health care reform plan. Its actuarial value would be based on the Blue Cross/Blue Shield standard option plan offered under the Federal Employees Health Benefits Plan.[2] Initially, those receiving subsidies would be required to buy the package, and employers would be required to offer it to their employees. After mandates were triggered, everyone would be required to buy it. Moreover, even without mandates, the bill would effectively force most people to purchase their insurance through a cooperative (or alliance) that likely would offer only the standard benefit plan.

Premiums for the Standard Benefit Package. For many, the standard coverage would be more generous than their current health insurance. However, the Congressional Budget Office (CBO) estimates that such a package would cost 3 percent less than the average private insurance benefit and 8 percent less than the package the Clinton administration originally proposed. Specifically, the CBO estimates that the average premiums for four types of policies in 1994 would be as follows:[3]

Single adult:	$2,220	One-Parent Family:	$4,329
Married Couple:	$4,440	Two-Parent Family:	$5,883

The actual premiums might be much higher. Private agencies estimated that the cost of premiums in the original Clinton plan would have been as much as 20 percent higher than the estimates of the CBO.[4]

Subsidies for the Purchase of Health Insurance. Beginning in 1997, subsidies for the purchase of health insurance would be available to low-income people and some employers. These subsidies would cover the full cost of the standard benefit package for those below the poverty level and would be phased out as income rises up to 200 percent of the poverty level, or about $32,000 for a family of four. For pregnant women and children, the subsidies would cover the full cost of insurance for those with incomes up to 185 percent of poverty and would be phased out as income rises up to 300 percent of poverty, or close to $50,000 for a family of four. Those on AFDC (Aid to Families with Dependent Children) would qualify for a 100 percent subsidy, regardless of income, and additional subsidies would be available for the unemployed. Employers who voluntarily expand health insurance coverage to workers previously not insured would receive temporary subsidies.

The CBO estimates that the cost of these subsidies would climb to over $100 billion per year by 1998, and to $194 billion by 2004. They would total $1.1 trillion between 1997 and 2004. [See Table A-I in the Appendix.] States would be responsible for determining eligibility and distributing the subsidies.

Community Rating. Under the Mitchell bill, community rating would apply to all health insurance sold to individuals and to employees who work for firms with fewer than 500 workers. After the year 2000, premiums would be the same for everyone, regardless of health status. Until the year 2000, variations would be allowed only for family size, geography and age. As a result, a new health insurance applicant with AIDS or cancer could not be charged any more than an applicant who is healthy.

"After the year 2000, premiums would be the same for everyone, regardless of health status."

The Mitchell bill also includes a guaranteed issue regulation, under which insurers would be required to accept all applicants regardless of health status.[5] Thus, those currently uninsurable would be able to buy insurance. Yet under community rating, they would pay only a small portion of the cost of their care, most of which would be paid through higher premiums for everyone else.

As a result of community rating, younger and healthier people would have to pay artificially high premiums in order to cover the higher costs of older and sicker people. In general, expected health care costs for adults ages 60 to 64 are two to three times as high as for people 25 to 29. According to one study of a similar pricing scheme proposed by President Clinton, premiums for people 25 through 29 would be 50 percent higher than otherwise, and people 26 through 34 would collectively pay $26 billion more per year.

Despite the fact that the Mitchell bill would initially offer generous subsidies to the uninsured in an attempt to induce them and their employers to purchase insurance voluntarily, it is possible that the number of uninsured would increase rather than decline. The reason is that the healthy would have an economic incentive to drop their insurance coverage, knowing that they could buy insurance at standard community rates if they became sick. As low-cost, healthy people dropped out of insurance pools, premium costs for those who remained would rise, encouraging even more healthy people to drop their coverage.

"About 500,000 people have dropped their coverage since the community rating law took effect in New York."

Consider the case of New York. In 1993, the state began requiring insurers to accept all applicants regardless of health status and to charge everyone the same premium for health insurance. According to the New York Department of Insurance, in the first year of community rating, almost 30 percent of the insured experienced premium increases ranging from 20 to 59 percent. Rates for a 30-year-old single male increased by 170 percent.[6] In response to these premium increases, large numbers of New Yorkers dropped their coverage and are now uninsured.

- The New York Department of Insurance estimates that about 44,000 individual policyholders have canceled their coverage since the law took effect,[7] but this estimate ignores the people who dropped their coverage in anticipation of the imposition of community rating.
- A study by Mark Litow and Drew Davidoff for the actuarial firm Milliman and Robertson, Inc. estimates that 500,000 New Yorkers with individual and small group policies canceled their policies, reducing the number of insured people directly affected by the new law from 2.8 million to 2.3 million.

Health Insurance Purchasing Cooperatives. The Mitchell bill ostensibly provides for *voluntary* health insurance purchasing cooperatives (HIPCs) as opposed to the mandatory alliances proposed by President Clinton. However, a number of provisions would have the effect of pushing a majority of people into HIPCs by making it difficult or impossible for a market for insurance to exist outside of them.

"The Mitchell bill is designed to push people into health insurance purchasing cooperatives (HIPCs)."

For example, the bill mandates that a HIPC be established for each geographic area, either by the state or by the Federal Employees Health Benefit Plan (FEHBP). Firms with fewer than 500 workers must offer their employees participation in a HIPC. If they also offer other plans, they must offer at least three, including a fee-for-service plan, a point-of-service plan (with different reimbursement rates for different providers) and a health maintenance organization (HMO). As a result, most firms would find it administratively easier simply to provide insurance through a HIPC.

Theoretically, a market for less expensive insurance could develop outside of HIPCs, but the bill has several provisions designed to keep that from happening. For example, insurers would be prohibited from offering coverage outside an alliance for a lower premium. Moreover, plans outside of alliances — including experience-rated plans — would be subject to a risk adjustment mechanism under which state governments could tax plans with healthier enrollees to subsidize those with sicker enrollees. In general, then, insurers would be unlikely to discover any advantage in selling insurance coverage outside of HIPCs.

Managed Competition. The reason why the Mitchell bill is designed to push people into HIPCs is that the central idea behind the Mitchell bill is managed competition.[8] As explained in earlier NCPA studies, the objective of managed competition is to create an artificial market for health insurance in which individuals choose among competing health plans that charge every applicant the same premium. Because of this one-price-for-all rule, the premiums of sick people would be well below the expected cost of their treatment, while the premiums of the healthy would be substantially higher. As a result, the incentives for the plans to avoid sick people and attract healthy ones would be far greater than under the current system.

Since sick people would be unprofitable, health plans not only would try to avoid them, they also would try to encourage patients with expensive-to-treat conditions to leave and join some other plan. Indeed, the natural tendency of managed competition would be to spend no more on the care of the sick than the sick pay in premiums. As a result, seriously ill people would be progressively denied access to the benefits of modern medical science.[9]

Could people avoid this outcome? The Mitchell bill states that individuals must be given an opportunity to join a fee-for-service plan, under which they could see any doctor of their choice. But such plans would tend to attract sick people with expensive-to-treat conditions and would be unlikely to survive in competition with managed care plans. Therefore, health economists expect that under managed competition most people would be forced to join HMOs, which could interfere with the doctor-patient relationship by telling doctors how to practice medicine in response to the financial incentives to underprovide to the sick.

Risk Adjustment. As health plans competed to attract the healthy and avoid the sick, some would be more successful than others. The most successful would be able to charge a lower (community-rated) premium, not because they had fewer services or were more efficient but because they had healthier enrollees. The Mitchell bill would force the states to create a risk adjustment mechanism to offset this result.[10] Under the scheme, regulators would take funds from plans with healthier enrollees and subsidize plans with sicker enrollees. Moreover, the risk adjustment is not confined to the community-rated market. Risk adjusters would have the power to "tax" the plans of firms with 500 or more employees, even though their employees were not participating in a cooperative. Even self-insured plans would face such assessments.

Changes in Medicaid. Medicaid recipients would purchase private insurance,[11] although in most cases their premiums would be fully paid by the government subsidies described above. Medicaid also would continue to cover any current services not contained in the standard benefit package.[12] When a Medicaid beneficiary joined a private insurance pool, the government would pay the community-rated premium charged to every member of the pool rather than a premium that reflected the higher expected costs of the Medicaid population. The CBO estimates that this cost shifting — discussed in greater detail below — would save the federal government $789 billion between 1997 and 2004. [See Table A-I.]

"Medicare spending would be reduced by $294 billion, while at the same time Medicare benefits would be expanded to include prescription drugs."

Changes in Medicare. The Mitchell bill also relies on reductions in Medicare spending to finance a good deal of the plan. Medicare — which is currently projected to grow at an annual rate of 11 percent — would be reduced by $294 billion between 1995 and 2004, primarily through further reductions in payments to hospitals and doctors. At the same time, Medicare benefits would be expanded to include prescription drugs at a cost of $95 billion.[13] The cost shifting that would be created by these funding cuts is also discussed in greater detail below.

Other Spending. Senator Mitchell's bill also would restructure the current system of government subsidies for medical education and academic health centers and would introduce new spending for long-term care, home health care, public health initiatives and administrative costs. The CBO estimates that spending in these areas would amount to $136 billion between 1995 and 2004.

Tax Increases. Over and above the spending financed by cuts in Medicare and Medicaid, the Mitchell bill would increase total federal outlays by a net of $248 billion between 1995 and 2004. To pay for these higher outlays, the bill would raise taxes by $262 billion. More than half would come from higher taxes on private insurance premiums — $74.3 billion from a 1.75 percent excise tax on all private insurance premiums and $70.4 billion from a special tax on high cost plans, discussed below[14] Other significant

revenue sources include raising tobacco taxes, excluding health benefits from cafeteria plans[15] and increasing the Medicare Supplementary Medical Insurance (Part B) premium for higher-income retirees. [See Table A-II.]

Most of these taxes would fall on the middle class. But two of the biggest revenue raisers — the tax on premiums and the higher tax on cigarettes — would create greater burdens on lower-income families. For example, the premium tax would tend to be the same for everyone, since the vast majority of people would be forced to accept the basic benefit package. But to the extent it was passed on to consumers, the tax as a percent of income would be higher for those earning less. Since smoking varies inversely with income, the increase in the cigarette tax also would fall disproportionately on lower-income families. In fact, the cigarette tax is probably the most regressive of all federal taxes.[16]

The Tax on High-Cost Health Plans. The Mitchell bill would impose a 25 percent tax on the insurance premiums of every health plan to the extent the plan exceeded government target limits on health care spending.[17] The target limits would equal the rate of inflation plus 2.0 percent — a rate well below the expected rate of increase in health care costs. The apparent purpose of the tax is to discourage high-cost health plans (which are often high-quality plans), perhaps even driving them from the market, and to encourage other plans to limit the amount they spend on health services for their enrollees.

It seems doubtful that this device would hold down health care spending. However, to the extent it alters private sector options, the tax would discriminate against fee-for-service plans because such plans have limited ability to restrain the health care spending of their enrollees. Unlike HMOs, these plans do not employ their own doctors and cannot easily prevent doctors from providing services they think their patients need. Thus, the vast majority of people would probably lose the choice of a fee-for-service plan and be forced into managed care. Only one group would be able to avoid the tax and any resulting limits on health care choices: labor unions, whose agreements the Mitchell bill exempts.

"The bill attempts to hold down costs by taxing high-cost insurance plans."

New Regulatory Bodies. The Mitchell proposal would create complex new regulatory bureaucracies, particularly at the state level. Mandates would further complicate state responsibilities. Without mandates in force, states would be responsible for: (1) determining eligibility for subsidies and the continuing Medicaid program, (2) administering subsidies and Medicaid, (3) establishing the infrastructure for the effective functioning of health care markets and (4) regulating and monitoring the health insurance industry.

These tasks would be enormously difficult. For example, at the end of each year, states would have to reconcile the income of each subsidized family with the premium subsidy it received. Such reconciliation might well be impossible. Federal tax information might be insufficient because definitions of tax income and taxpayer unit might differ from subsidy income and subsidy unit. Even if tax return data could be used, many who qualified for subsidies might not be required to file tax returns. And many would require tracking as they moved from one state to another.

Overseeing the insurance market would present another nightmare for states. Among the myriad of new duties, each state would have to determine the risk adjustments to be made for all community-rated and experience-rated plans in each community-rating area. States also would have to produce annual standardized reports comparing the performance of all health plans in the state; certify standard health plans and purchasing cooperatives; establish separate guaranty funds for community-rated and self-insured health plans; monitor variation in the marketing fees of HIPCs and other insurance purchasing mechanisms; and ensure that insurance carriers met minimum capital requirements.

The CBO's assessment, "It is doubtful that all states could develop the capabilities to perform these functions effectively in the near future,"[18] surely is an understatement.

The Misplaced Focus of the Mitchell Bill

"On the average, patients pay only 21 cents out-of-pocket every time they spend a dollar on medical care."

The most important health care problem the nation faces is rising health care costs. The problem arises because of the nature of third-party payment of medical bills. On the average, patients pay only 21 cents out of their own pockets every time they spend a dollar in the medical marketplace. This fact gives people an incentive to overconsume medical care until it is worth only 21 cents on the dollar to them at the margin. Not only are people encouraged to overconsume, but the structure of third-party payment encourages patients and their doctors to choose inefficient therapies. Elsewhere we have estimated that these distortions produce at least $180 billion worth of waste per year.[19]

Early in its term, the Clinton administration seemed to acknowledge that cost was the most important problem. Although the Clintons talked about universal coverage much more than cost control, the administration never proposed a feasible way to get the last 5 or 6 percent of the population covered; and in an unguarded moment, even the president suggested that goal was unattainable.[20] Cost control is a different matter. The administration proposed mandatory health alliances (HIPCs), price controls and global budgets. However imperfect the methods, the desire to achieve the goal was clear.

"The focus of the Mitchell bill is on shifting costs from the government to the private sector."

The Mitchell bill is very different. Gone are the mandatory alliances, price controls and global budgets. But we can still look to the details of the plan to determine Senator Mitchell's priorities. And *those priorities are clearly the priorities of Capitol Hill.* The Mitchell plan shows little interest in controlling health care costs for the nation as a whole. Indeed, health care spending would go up, not down, as a result of the Mitchell bill. The CBO claims that without reform, health care spending will consume 20 percent of GDP by the year 2003. President Clinton's original goal was to lower that figure to 19 percent. However, the CBO and the Joint Committee on Taxation predict that the Mitchell bill would *increase* spending to 21 percent — more than would be spent without health care reform.[21]

Instead of controlling costs for the nation as a whole, the focus of the Mitchell bill is on controlling costs for government and, whenever possible, shifting costs from the public to the private sector. For example:

- Employer mandates are an attempt to shift subsidies for lower-income families from government to employers.
- Enrolling Medicaid beneficiaries in private health plans at community-rated premiums would shift part of the cost of Medicaid to those with private insurance.
- Cutting back on Medicare reimbursement rates for doctors and hospitals would shift more of the cost of Medicare to private sector patients.
- The Mitchell bill even has a trigger that would reduce the level of government subsidies — but only if *government's* costs exceed a target.

The CBO estimates that mandates would decrease federal outlays by $66 billion.[22] This is because mandates would mean more private insurance through the workplace and fewer subsidies for low-income people. This gain to the federal government would be partly offset by about $41 billion in lower tax receipts. [See Table A-III.] The federal government would lose income and payroll tax revenue if more people received employer-provided health insurance that was excluded from taxable income.

The (government) cost containment trigger works like this: The proposal would scale back the premium subsidies, Medicare drug benefit and other new spending if costs turned out to be at least $10 billion higher than initial estimates. Because the reductions would be across-the-board, most would come out of the low-income subsidies.

Static Forecast: Cost Shifting to the Middle Class

One reason why there is so much uncertainty about the real cost of congressional health reform proposals is that many of the costs are hidden. For example, for every $1 in direct taxes under the Mitchell bill at least another $2 and possibly as much as $4 in indirect costs would be imposed on the private sector.

"For every $1 in direct taxes, the Mitchell bill would impose at least another $2 and possibly as much as $4 in indirect costs."

The private sector would experience these indirect costs primarily as higher health insurance premiums caused by government's moving Medicaid recipients into private health insurance and underpaying their premiums. The private sector also would face higher hospital charges and physician fees caused by government's expanding Medicare benefits while reducing total Medicare payments to providers. In addition to cost shifting from Medicaid and Medicare, the private sector would have to make up the loss of federal revenue caused by the negative impact of the plan on the economy.

The Debate Over Cost Shifting. Cost shifting occurs when one group of patients pays less than the true cost of its medical care. In order to stay solvent, providers must cover the losses by overcharging everyone else. No one knows precisely how much cost shifting there is, and its magnitude is open to debate. The CBO estimates that the uninsured pay for only about 30 percent of the health care they get each year. As a result:

- The CBO estimates that in 1991 the uninsured received about $15.2 billion in "uncompensated" hospital care and another $10.2 billion in "uncompensated" physician services.
- After making some adjustments, the CBO estimates that the uninsured caused a total of $20.3 billion in costs to be shifted to paying patients that year.
- Based on CBO assumptions, we estimate that figure will reach $53 billion by the year 2003 without health care reform. [See Figure I.]

A more important source of cost shifting is the low rate of reimbursement by Medicare and Medicaid. These two programs routinely pay less than the real cost of the services their beneficiaries receive. Yet hospitals and doctors must either accept their rates or be excluded from the programs. Specifically:[23]

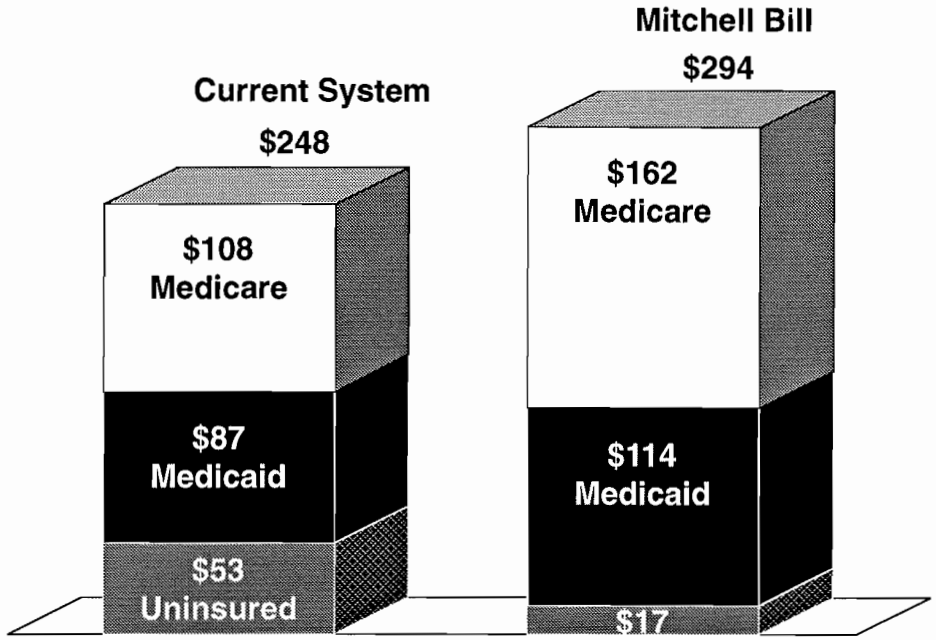
- According to the CBO, Medicare payments to hospitals and doctors are only 70 percent of private patient payments and Medicare reimbursement for all services is only 80 percent of private charges.
- Medicaid payments to hospitals and doctors are 63 percent and 45 percent of private payments, respectively.

"Cost shifting will reach $294 billion by 2003 under the Mitchell bill."

FIGURE I

Cost Shifting Under the Mitchell Bill

($ billions; year 2003)



Note: The figure shows the underpayment of medical bills and health insurance premiums by Medicare, Medicaid and the uninsured. These estimates are static and do not take into account the behavioral changes that would result from changed incentives.

- Based on the CBO assumptions, we estimate that, without health care reform, by the year 2003 about $108 billion will be shifted to the private sector from Medicare and $87 billion from Medicaid. [See Figure I.]

Not all health economists agree with the CBO. In a study produced for the American Enterprise Institute, Professor Michael Morrisey argues that there is very little cost shifting. When the government underpays for Medicare and Medicaid patients, Morrisey says those patients tend to receive lower-quality (less costly) care.[24]

Cost Shifting by Providers. If more people were insured, Mitchell and others argue, there would be fewer costs to shift from the uninsured. Using CBO assumptions, we estimate that this type of cost shifting would fall from $53 billion to $17 billion in 2003 as a result of the Mitchell bill. But that is only half of the story. Because of increased benefits and reduced funding, Medicare cost shifting would grow by $54 billion in 2003. Thus the cost shifting caused by cuts in Medicare funding alone would more than offset the reduction in unpaid bills caused by insuring the uninsured. On balance, medical bills for paying patients *would go up, not down, as a result of the Mitchell bill.*

Cost Shifting in Health Plans. Even if Morrisey is right about the inability of providers to shift costs, there is no doubt that, under the Mitchell bill, cost shifting within private insurance pools would be enormous. That's because Mitchell would put all Medicaid enrollees in private health plans, where they could see any doctor or enter any hospital. Because Medicaid patients use about twice as much health care as other people, they are much more expensive to insure. And under the Mitchell bill, they would receive more benefits (e.g., recipients of Aid to Families with Dependent Children would pay only one-fifth the deductible paid by others). Nonetheless, the government would pay insurers the same premium other enrollees pay. We predict that this underpayment of premiums would cause the private sector to be overcharged by $114 billion in the year 2003.

Cost of the Mitchell Bill: Low Estimate. The Mitchell bill would impose 17 new taxes designed to raise $42 billion per year by 2003. These are the direct costs of the plan. An indirect cost is imposed through the plan's negative effects on the economy. The high marginal tax rates (discussed below) would lead to less work and less production, lowering national income by $65 billion in the year 2003. Even if we attribute this loss of income totally to those who reduce their work effort, the rest of society would still be worse off. That is because, with less national income, government would collect about $33 billion less in taxes, and general taxpayers would have to make up the revenue shortfall. The other indirect costs are shifted costs. Assuming the CBO is correct about the ability of health providers to shift costs, we estimate that:

"The Mitchell bill would increase costs for middle-class families by as much as $2,000 per household per year by 2003."

- The Mitchell bill would increase costs for middle-class families by about $121 billion in the year 2003. [See Figure II.]
- This equals a cost of more than $1,000 per household per year.

Cost of the Mitchell Bill: High Estimate. Figure II also shows the cost of the Mitchell bill, assuming that providers could not shift Medicaid costs and could shift only one-half the costs of government underpayment for Medicare patients and the uninsured. Under these assumptions, we estimate that:

- The total cost of the Mitchell bill for middle-class families in 2003 would be almost $200 billion.
- This equals a cost of almost $2,000 per household per year.

Static Forecast: Effects on the Elderly

The American Association of Retired Persons (AARP) has endorsed the Mitchell bill as well as another version of the Clinton health care plan: a bill by Representative Richard Gephardt (D-MO).[25] In doing so, AARP has

betrayed its members. Even though both bills promise new benefits for the elderly, including prescription drugs and home health care, they do nothing to pay for the benefits. As noted above, both bills would cut Medicare funding by billions of dollars. The consequence would be an ever-widening gap between the cost of promised benefits and the amount Medicare is willing to pay:

- Under the Mitchell bill, underpayment of medical expenses by Medicare would more than triple — growing from $44 billion this year to $162 billion by the year 2003. [See Figure III.]
- As a result, Medicare reimbursements to hospitals, doctors and other providers in 2003 would be only 70 percent of the actual cost of treating Medicare patients, compared with 80 percent today.
- Thus almost one out of every three health services for the elderly would have to be either rationed or paid for by shifting the costs to other patients.

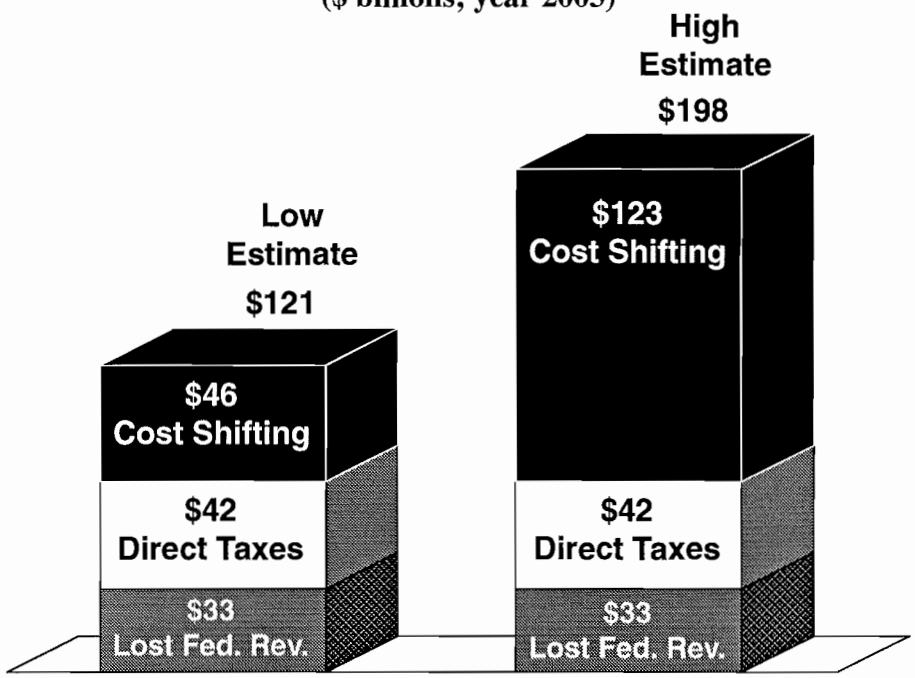
Medicare's Bleak Future. The best-kept secret in the current health care debate is that Medicare is already in trouble. Because the Medicare

"Middle-class families would pay $42 billion in direct taxes and as much as $156 billion in hidden costs."

FIGURE II

Cost of the Mitchell Bill for Middle-Class Families

($ billions; year 2003)



Note: The figure shows the underpayment of medical bills and health insurance premiums by Medicare, Medicaid and the uninsured. These estimates are static and do not take into account the behavioral changes that would result from changed incentives.

payment gap is growing, Medicare recipients will have increasing difficulty obtaining the benefits they supposedly are entitled to. Even with no change in the current health care system, over the next ten years about one out of every five health care services for the elderly will have to be rationed or paid for by shifting costs to other patients.

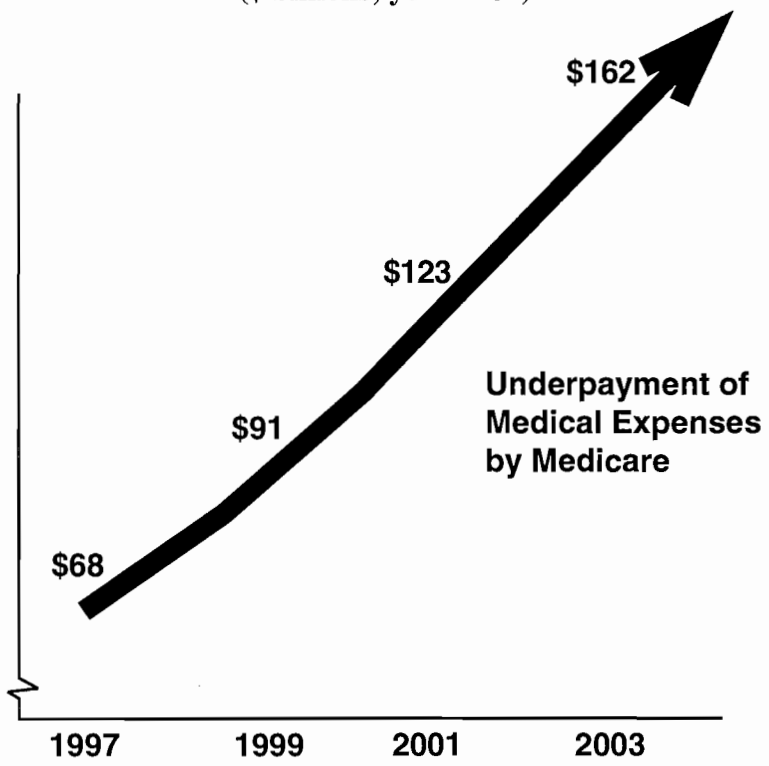
As noted above, Professor Michael Morrisey argues that there is very little cost shifting. When the government underpays for Medicare and Medicaid services, Morrisey says, the patients tend to receive lower-quality (less costly) care. Morrisey's argument is more persuasive with respect to Medicaid patients (who are restricted to the few doctors willing to treat them and the few hospitals willing to admit them) than to Medicare patients (who have many more options). However, in the future even Medicare patients may find it impossible to get part of their costs shifted to other patients. The reason is that the medical marketplace is increasingly competitive. In competitive markets, cost shifting is impossible because prices reflect the true cost of services and providers are unable to charge one person more than another.

"Underpayment of medical expenses by Medicare would more than triple."

FIGURE III

Clinton/Mitchell Bill

($ billions; year 2003)



Note: The figure shows the amount by which Medicare reimbursements to hospitals, doctors and other providers would fall short of the actual cost of treating Medicare patients. Either these costs would be shifted to other patients or the elderly would receive reduced quality care or rationed care. These estimates are static and do not take into account the behavioral changes that would result from changed incentives.

Medicare vs. Medicaid. Under the current system, Medicaid underpays even more than Medicare. But both Democratic versions of Clinton health reform would greatly expand options for the poor, even as they create pressures to ration care for the elderly.

- As noted above, Medicaid patients under the Mitchell bill would join private health plans and have their premiums paid by the government.
- Since private insurers reimburse providers at much higher rates than does the Medicaid program, Medicaid beneficiaries would have the same options as private patients.
- Thus Medicaid patients would have far more options and get better medical care than the elderly.

Under the Gephardt bill, Medicaid recipients would be put into a new Medicare Part C program, which presumably would reimburse providers at the same rate as the Medicare program for the elderly (Parts A and B). But since the bill also allows millions of other Americans to enroll in Medicare Part C, the program eventually would cover about half the U.S. population. As a result, the Medicare underpayment gap would become so huge that the cost shifting required would be impossible. A two-tier system of health care would likely emerge, under which the best doctors would simply refuse to see Medicare patients and the best hospitals would refuse to admit them.

"Medicaid patients would have more options and get better medical care than the elderly."

Dynamic Forecast: Effects on the Economy

The static forecasts presented in the previous two sections were based on the first-round effects of Mitchell health reform. They did not consider how people would change their consumption of health services in light of the lower required out-of-pocket payments. Nor did they consider how the expanded health care sector would affect the rest of the economy, including capital markets.

We used the National Center for Policy Analysis/Fiscal Associates Health Care Model to produce a dynamic forecast of the Mitchell bill's effects. The model links to the rest of the economy via the Fiscal Associates Tax Model that explicitly incorporates detailed information on tax policy and its effect on the economy, capital investment, output and jobs.

To simulate the economic effects of the Mitchell proposal, we first produced a baseline using the latest CBO projections of economic performance and health care spending under current law.[26] We than produced *dynamic* simulations of what would happen to the health care sector and the economy if the Mitchell proposal were enacted. We used the CBO's initial estimates of the national average premiums, tax revenues, subsidies and other outlays under the Mitchell proposal *without mandates* from 1995 through 2004.[27]

Effects on Health Spending. The Mitchell proposal would increase demand for medical services because out-of-pocket spending would decline about 6 percent compared with the baseline. Although direct government spending on Medicare and Medicaid would decrease, tax subsidies and new direct subsidies for insurance would increase by 50 percent. [See Table A-IV.]

Because of the drop in the price of health care to consumers, U.S. health spending would increase by $81 billion over the baseline between 1995 and 1999. As noted above, if there were no negative effects on the economy, the health care sector would continue to grow and health spending would continue to be higher than otherwise, indefinitely into the future. However, as noted below, the expansion of the health care sector would have a negative impact on the rest of the economy. This impact, combined with new taxes and work-discouraging subsidies, would cause the entire economy to contract. And since health spending is positively related to income, a fall in national income would lead to a fall in health care spending. Thus, beginning in the year 2001, health spending would fall below the baseline. [See Table A-IVA.]

Effects on the Economy. The Mitchell bill would have a negative impact on the economy for three reasons. First, the $262 billion in tax increases between 1995 and 2004 would depress economic activity. Most damaging would be the special taxes on insurance premiums, the increase in tobacco excise taxes and the exclusion of health benefits from cafeteria plans.

Second, the phase-out of subsidies at higher levels of income would create extremely high effective marginal tax rates on labor. The CBO notes that the effective marginal tax rate on labor compensation could increase by as much as 30 to 55 percentage points for workers in the phase-out range. After payroll taxes, income taxes and the phase-out of the earned income tax credit, some low-wage workers would get to keep only 15 cents out of an extra dollar of earnings.[28] The Heritage Foundation has calculated that when the food stamps phase-out is included, some workers would keep only 5 cents out of each extra dollar of earnings. [See Figure IV.] We estimate that the economy-wide average marginal tax rate on labor would go up by one percentage point, a substantial increase.

"The reduction in GDP would equal more than $1,000 per household."

Third, because initially more would be spent on health care than under current law, more resources would be switched from other sectors of the economy. However, expanding the supply of medical services causes production costs to go up much more rapidly than does expanding the supply of other goods and services. As we have noted in previous NCPA publications, moving capital and labor into the health care sector costs the economy several times more in other goods and services than the gain in medical services.[29]

By the year 2005, these negative effects on the economy would produce the following consequences:

- Annual GDP would be $133 billion lower than otherwise, an amount equal to more than $1,000 per year per household.
- Spending on health care would decrease by $59 billion, and output of other goods and services would be reduced by $74 billion.
- U.S. workers would find 861,000 fewer jobs and lose $54 billion per year in wages.

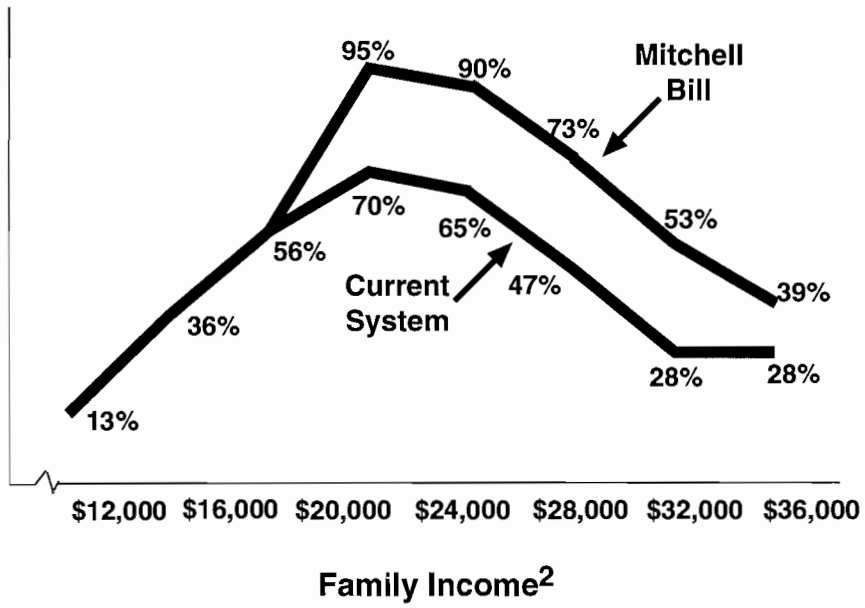
Mitchell vs. Clinton. How does the Mitchell plan compare with the original Clinton health care reform plan, on which it was based? As noted above, the Mitchell plan initially avoids the employer mandates in the Clinton plan. It also has lower taxes. For example, by the end of the decade, new

"The effective marginal tax rate could reach 95 percent for some workers."

FIGURE IV

Marginal Tax Rates for Low- to Moderate-Income Families[1]

(1996)



[1] Shows the combined effects of the federal income tax and Social Security (FICA) taxes and the phase-out of the Earned Income Credit, the Food Stamp program and health insurance subsidies under the Mitchell bill (with no employer mandate).

[2] Pretax income, including the employer's share of Social Security (FICA) taxes. All figures are for a family of four (husband, wife and two children).

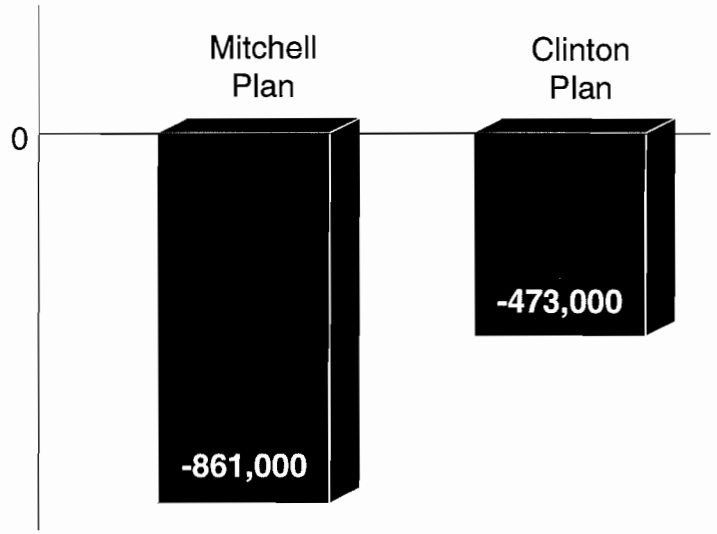
Source: Stuart M. Butler and Robert Rector, "Health Care Talking Points #10: The Mitchell Bill's Punitive Penalty on Work," Heritage Foundation F.Y.I., August 22, 1994, Table I, p. 3.

"By 2005, there would be 861,000 fewer jobs than otherwise."

FIGURE V

Loss of Jobs Under the Clinton and Mitchell Health Care Plans

(year 2005)

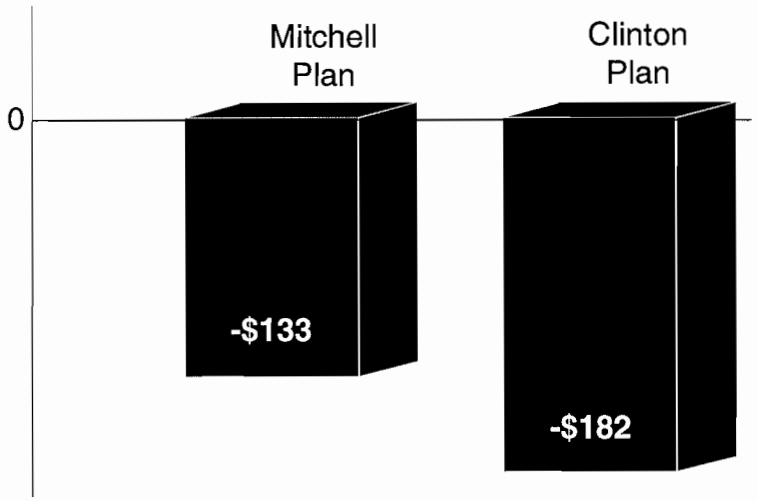


"The Mitchell bill would cost more jobs, but the Clinton plan would have a more unfavorable impact on the overall economy."

FIGURE VI

Loss of Output Under the Clinton and Mitchell Health Care Plans

($ billions; year 2005)



taxes would total $53 billion per year under Clinton, but only $28 billion under Mitchell. Yet the Mitchell bill has a much more negative impact on the labor market.

In an earlier analysis of the Clinton plan, we forecast that job losses would peak at 783,000 in the year 2000 and then begin to ameliorate — reaching 473,000 lost jobs by the year 2005.[30] Under the Mitchell bill, job losses would peak at 918,000 in the year 2002 and then begin to ameliorate. They would still total 861,000 in the year 2005, however — almost twice the number of jobs the Clinton plan would destroy. [See Figure V.]

Why is the Mitchell bill worse for the labor market? The main reason is the way in which the subsidies are withdrawn. Under the Clinton plan, the withdrawal adds only about 4 percentage points to the marginal tax rates of affected workers — about one-tenth as much as under the Mitchell plan.

However, while the Mitchell plan is worse for labor, the Clinton plan is worse for the economy as a whole. As Figure VI shows, loss of total output in the year 2005 would be $133 billion under Mitchell, compared with $187 billion under Clinton.

Effects on Government Budgets. Estimates from the National Center for Policy Analysis/Fiscal Associates Health Care Model show that the Mitchell plan without mandates would increase the federal deficit by $152 billion between 1996 and 2005. This contrasts with the CBO's estimate that the bill would decrease the deficit by $13.8 billion between 1995 and 2004. [See Tables A-III and A-VI.] The primary reason for the difference is that our forecast predicts the loss in federal revenues due to slower economic growth. Although state and local governments would find their spending on health programs reduced, slower growth would also trim tax collections. On net, the Mitchell proposal would add $65 billion to state and local deficits between 1996 and 2005. [See Table A-VII.]

Effects on Household Budgets. American households would also lose. By the year 2005, the annual value of consumption goods and services would be $133 billion less per year than otherwise. [See Table A-VIII.] On the average, the Mitchell plan would reduce the annual value of consumption by about $850 for the every American household.

Conclusion

Even without mandates, the Mitchell proposal would cause serious damage to the U.S. economy, produce significant job losses and fail to contain health care spending. Further, the ability of the plan to expand health insurance coverage to more Americans is questionable. Premiums could well turn out to be much higher than CBO estimates, and the requirement of guaranteed issue and community rating could induce a significant number of people to

"The complex administrative burdens of the Mitchell bill are almost certainly unworkable."

drop their insurance coverage and go uninsured until they got sick. As a result, the bill could easily lead to less coverage, particularly among the population not eligible for subsidies. Finally, the complex administrative burdens placed on the federal and state governments would almost certainly be unworkable, dooming the Mitchell proposal to failure even before it began.

Notes

[1] Employee Benefit Research Institute, "Sources of Health Insurance and Characteristics of the Uninsured," EBRI Special Report, January 1994.

[2] See "Is Hawaii a Model for Health Care Reform?" National Center for Policy Analysis, NCPA Brief Analysis No. 126, August 19, 1994; and General Accounting Office, "Health Care in Hawaii: Implications for Reform," GAO/HEHS-94-68, February 1994.

[3] The 16 legislatively defined categories of covered services are: hospital; health professional; emergency and ambulatory medical and surgical; clinical preventive; mental illness and substance abuse; family planning and services for pregnant women; hospice; home health; extended care; ambulance; outpatient laboratory, radiology and diagnostic; outpatient prescription drugs; outpatient rehabilitation; durable medical equipment, prosthetics and orthotics; vision, hearing and dental care for those under age 22; and investigational treatments.

[4] The purpose of alliances is to impose managed competition on the health care system, and advocates of managed competition are virtually unanimous in the belief that all insurers should be forced to offer a uniform benefit package and no other. Thus, although the bill does not outlaw other benefit packages, it is unlikely that alliances will allow them.

[5] Congressional Budget Office, "A Preliminary Analysis of Senator Mitchell's Health Proposal," Washington, DC, August 9, 1994, p. 3.

[6] See William Custer, "Health Reform: Examining the Alternatives," Employee Benefit Research Institute, *EBRI Issue Brief* No. 147, March 1994, Table 7, p. 22.

[7] Companies would have to pay at least half the insurance premiums. First-year subsidies would equal the difference between half the average insurance premium in the area and 8 percent of the worker's wage. These employer subsidies would phase out over four years.

[8] Those with a medical condition that appeared within three months prior to enrollment may be excluded for up to six months after the date of enrollment.

[9] David A. Bradford and Derrick A. Max, "Soak-the-Young Economics of Clinton's Health Care Plan," *On the Issues,* American Enterprise Institute, 1994.

[10] Tony Hammond, "The Facts on Community Rating," Health Insurance Association of America, May 1994.

[11] Leslie Scism, "New York Finds Fewer People Have Health Insurance a Year After Reform," *Wall Street Journal*, May 27, 1994.

[12] Mark E. Litow and Drew S. Davidoff, "The Impact of Guaranteed Issue and Community Rating in the State of New York," Milliman and Robertson, Inc., August 18, 1994.

[13] For the theory behind managed competition and the general policy proposals made by its advocates, see Alain C. Enthoven, *Health Plan: The Only Practical Solution to the Soaring Cost of Medical Care* (Reading, MA: Addison-Wesley, 1980); Alain C. Enthoven, "The History and Principles of Managed Competition," *Health Affairs* (Supplement 1993), pp. 24-48; and Alain C. Enthoven, Paul M. Ellwood and Lynn Etheridge, "The Jackson Hole Initiatives for a Twenty-First Century American Health Care System," *Health Economics* 1, 1992.

[14] See John C. Goodman and Gerald L. Musgrave, "Primer on Managed Competition," National Center for Policy Analysis, NCPA Policy Report No. 183, April 1994. See also "Managed Competition: Hazardous to Your Health," National Center for Policy Analysis, NCPA Brief Analysis No. 117, July 22, 1994.

[15] For an analysis of risk adjustment mechanisms and the problems of implementing them, see Joseph Newhouse, "Rate Adjusters for Medicare Under Capitation," *Health Care Financing Review* (1986 Annual Supplement), pp. 45-56, cited in Enthoven, "The History and Principles of Managed Competition," pp. 33-34; Michael Moore, "Risk Adjustment Under Managed Competition," Jackson Hole draft discussion paper, March 1993; and Wynand P.M.M. Van de Ven and René C.J.A. Van Vliet, "How Can We Prevent Cream-Skimming in a Competitive Health Insurance Market?" in P. Ziveifel and H. E. Frech III, eds., *Health Economics Worldwide* (Dordrecht, Netherlands: Kluwer Academic Publishers, 1992), pp. 23-46.

[16] The exception is those also on Supplementary Security Income or Medicare.

[17] States would make maintenance of effort payments to the federal government. For each AFDC recipient receiving a subsidy in any year, states would pay their fiscal year 1994 per capita cost of covered services adjusted for the growth in per capita national health expenditures between 1994 and that year.

[18] The Secretary of Health and Human Services would set the deductible so that the net incurred cost of the benefit would total $13.4 billion in the first year. CBO estimates the initial deductible to be $700. The deductible would go up after that so that the same percentage of Medicare beneficiaries would receive some drug benefit.

[19] A 25 percent tax would be imposed on the amount by which health insurance premiums for a standard plan exceeded a "reference" premium. Each class of coverage in each community-rating area and each experience-rated plan would have its own reference premium established annually by the Secretary of Treasury.

[20] The current tax on cigarettes is 24 cents a pack. The Mitchell bill would increase the tax to 69 cents per pack.

[21] Under the current law, employees are able to pay their share of health insurance premiums and deductibles, copayments and other medical expenses not paid by their employer's plan with pretax dollars deposited to Flexible Spending Accounts (FSAs). This option would be abolished under the Mitchell bill. For a discussion of FSAs and their treatment under the tax law, see Alain C. Enthoven, "Health Policy Mismatch," H*ealth Affairs,* Winter 1985, pp. 5-13.

[22] See "Do Higher Cigarette Taxes Make Sense?" National Center for Policy Analysis, NCPA Brief Analysis No. 123, August 16, 1994.

[23] Community-rated markets would be subject to the tax in 1997; experienced-rated plans would not be subject to it until 2000. The Secretary of Treasury would have to establish a reference premium for each class of coverage in each community-rating area and each experience-rated plan annually.

[24] CBO, "A Preliminary Analysis of Senator Mitchell's Health Proposal," p. 11.

[25] See Gary Robbins, Aldona Robbins and John Goodman, "How Our Health Care System Works," National Center for Policy Analysis, NCPA Policy Report No. 177, February 1993.

[26] See Gary Robbins, Aldona Robbins and John Goodman, "Inefficiency in the U.S. Health Care System: What Can We Do?" National Center for Policy Analysis, NCPA Policy Report No. 183, April 1994.

[27] On the general unachievability of universal coverage, see, "The Myth of Universal Coverage," National Center for Policy Analysis, NCPA Brief Analysis No. 103, February 14, 1994.

[28] CBO, "A Preliminary Analysis of Senator Mitchell's Health Proposal," Table 6.

[29] Because of the problems that would arise from implementing mandates in some states but not others, the CBO estimates assume that a nationwide mandate would be in effect.

[30] Congressional Budget Office, "Single-Payer and All-Payer Health Insurance Systems Using Medicare's Payment Rates," CBO Staff Memorandum, April 1993, p. 9.

[31] CBO, "Single-Payer and All-Payer Health Insurance Systems Using Medicare's Payment Rates," pp. 7-8.

[32] Michael Morrisey, *Cost Shifting in Health Care: Separating Evidence from Rhetoric* (Washington, DC: American Enterprise Institute, 1994).

[33] For an analysis of the Gephardt bill, see Peter J. Ferrara, "Senator Mitchell's Last Stand," National Center for Policy Analysis, NCPA Policy Backgrounder No. 134, August 24, 1994.

[34] Congressional Budget Office, "Projections of National Health Expenditures: 1993 Update," CBO Memorandum, Washington, DC, October 1993, and Congressional Budget Office, *The Economic and Budget Outlook: Fiscal Years 1995-1999* (Washington, DC: U.S. Government Printing Office, January 1994), Chapter 1.

[35] CBO, "A Preliminary Analysis of Senator Mitchell's Health Proposal." CBO revenue and outlay estimates were converted from fiscal to calendar years. We did not assume the across-the-board cutbacks in subsidies if the proposal went over budget or that mandates would go into effect. Results under either would be worse for the economy and government deficits.

[36] CBO, "A Preliminary Analysis of Senator Mitchell's Health Proposal," p. 16.

[37] Robbins, Robbins and Goodman, "How Our Health Care System Works."

[38] Gary Robbins and Aldona Robbins, "Forecasting the Effects of the Clinton Health Plan," National Center for Policy Analysis, NCPA Policy Report No. 185, May 1994.

TABLE A-I

Preliminary CBO Estimates of the Effect of Senator Mitchell's Proposal On Federal Outlays Without Mandate in Effect

(By fiscal year, in billions of dollars)

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	Total
Mandatory Outlays	**-2.4**	**-4.9**	**11.1**	**24.7**	**33.4**	**41.3**	**39.2**	**39.0**	**37.9**	**35.9**	**255.2**
Medicaid	*	*	**-51.4**	**-76.0**	**-84.4**	**-93.2**	**-104.3**	**-114.8**	**-126.2**	**-138.3**	**-788.6**
Medicare	**-2.4**	**-6.6**	**-10.2**	**-14.1**	**-14.7**	**-14.3**	**-21.1**	**-28.9**	**-38.1**	**-48.4**	**-198.8**
Part A & B Changes	-2.4	-6.6	-10.2	-14.1	-20.9	-28.7	-36.8	-46.4	-57.8	-69.9	-293.8
Prescription Drug Benefit	0.0	0.0	0	0	6.2	14.4	15.7	17.5	19.7	21.5	95.0
Subsidies	**0.0**	**0.0**	**68.0**	**103.7**	**117.6**	**131.3**	**146.1**	**161.6**	**177.9**	**194.3**	**1,100.5**
Persons between 0-200% of Poverty[1]	0.0	0.0	66.7	95.4	105.3	116.8	129.3	142.7	157.3	172.3	985.8
Temporarily Unemployed	0.0	0.0	0.0	5.0	7.1	7.7	8.3	9.0	9.8	10.6	57.5
Enrollment Outreach	0.0	0.0	1.3	3.3	5.2	6.9	8.4	9.9	10.8	11.3	57.1
Other Health Programs	**0.0**	**0.3**	**1.3**	**6.7**	**10.0**	**12.6**	**14.1**	**17.2**	**20.8**	**24.6**	**107.6**
Public Health Initiatives	**0.0**	**1.4**	**3.2**	**3.9**	**4.0**	**3.9**	**3.5**	**3.0**	**2.8**	**2.9**	**28.6**
Social Security Benefits[2]	**0.0**	**0.0**	**0.2**	**0.5**	**0.9**	**0.9**	**0.9**	**0.9**	**0.8**	**0.8**	**5.9**
Discretionary Outlays	**2.5**	**3.2**	**0.3**	**-1.7**	**-2.3**	**-0.4**	**-0.5**	**-2.6**	**-2.8**	**-2.9**	**-7.2**
Health Programs	**1.9**	**1.8**	**-1.4**	**-3.1**	**-3.3**	**-3.4**	**-3.6**	**-3.7**	**-3.9**	**-4.1**	**-22.8**
Administrative Expenses	**0.6**	**1.3**	**1.6**	**1.3**	**1.0**	**3.0**	**3.1**	**1.1**	**1.1**	**1.2**	**15.3**
Studies, Research, & Demonstrations	*	**0.1**	**0.1**	**0.1**	*	*	*	*	*	*	
Total Outlay Changes	**0.1**	**-1.6**	**11.4**	**22.9**	**31.1**	**40.9**	**38.7**	**36.3**	**35.1**	**33.0**	**247.9**

* Less than $50 million.

[1] Includes pregnant women and children from 0 to 300 percent of poverty.

[2] Higher outlays because low-income subsidies would encourage early retirement.

Source: Congressional Budget Office, "A Preliminary Analysis of Senator Mitchell's Health Proposal," Washington, DC, August 9, 1994, Table 1. The figures in this table include changes in authorizations of appropriations and in Social Security that would not be counted for pay-as-you-go scoring under the Budget Enforcement Act of 1990.

TABLE A-II

Preliminary CBO Estimates of the Effects of Senator Mitchell's Proposal on Federal Revenues and Deficit Without Mandate in Effect

(By fiscal year, in billions of dollars)

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	Total
Receipts	**0.1**	**7.1**	**15.7**	**20.2**	**24.5**	**28.3**	**33.4**	**37.8**	**43.5**	**51.2**	**261.8**
1.75% Excise Tax on Private Ins. Premiums	0	3.5	6.1	7.1	7.7	8.4	9.1	9.9	10.8	11.7	74.3
Impose Premium Tax with Respect to Certain High-Cost Plans	0	*	0.9	2.2	3.3	6.1	9.5	12.5	16.0	19.9	70.4
Increase in Tobacco Tax	0.7	2.7	4.5	6.1	7.6	7.4	7.1	6.9	6.8	6.7	56.5
Provide That Health Benefits Cannot be Provided thru Cafeteria Plan/Flex Spend Arrangements	0	0.5	2.5	3.9	4.8	5.6	6.3	7.0	7.7	8.5	46.8
Additional Medicare Part B Premiums for High-Income Individuals ($80,000/$100,000)	0	0	2.0	2.0	2.8	3.5	4.4	5.5	6.9	8.7	35.8
Extend/Increase 25% Deduction for Health Insurance Costs of Self-Employed Individuals	-0.5	-0.6	-1.2	-1.3	-1.4	-1.5	-1.6	-1.8	-2.0	-2.1	-14.0
Indirect Tax Effects of Changes in Tax Treatment of Employer and Household Health Ins. Spending	0	-0.5	-0.3	-0.7	-1.3	-2.0	-2.4	-3.0	-3.3	-3.7	-17.2
Other Receipt Changes	-0.1	1.5	1.2	0.9	1.0	0.8	1.0	0.8	0.6	1.5	9.2
Deficit											
Mandatory Changes	**-2.5**	**-12.0**	**-4.6**	**4.5**	**8.9**	**13.0**	**5.8**	**1.2**	**-5.6**	**-15.3**	**-6.7**
Total Changes	**0**	**-8.7**	**-4.3**	**2.7**	**6.6**	**12.6**	**5.3**	**-1.5**	**-8.4**	**-18.2**	**-13.8**

* Less than $50 million.

Source: Congressional Budget Office, "A Preliminary Analysis of Senator Mitchell's Health Proposal," Washington, DC, August 9, 1994, Table 1. The figures in this table include changes in authorizations of appropriations and in Social Security that would not be counted for pay-as-you-go scoring under the Budget Enforcement Act of 1990.

TABLE A-III

Comparison of the Federal Budgetary Effects of the Mitchell Proposal With & Without Mandates in Effect

(By fiscal year, in billions of dollars)

	Totals for 1995 through 2004	
	Without Mandate	With Mandate
Mandatory Outlays	**255.2**	**183.4**
Medicaid	-788.6	-788.6
Medicare	-198.8	-198.8
Subsidies	1,100.5	1,028.3
Persons between 0-200% of Poverty[1]	985.8	929.5
Temporarily Unemployed	57.5	71.2
Enrollment Outreach	57.1	20.7
Other Health Programs	142.1	142.5
Discretionary Outlays	**-7.2**	**-1.2**
Administrative Expenses	15.3	21.3
Total Outlay Changes	**247.9**	**182.2**
Receipts	**261.8**	**220.6**
1.75% Excise Tax on Premiums	74.3	76.2
No Cafeteria Plan/Flex Spend Arrangements	46.8	51.8
Tax on High Cost Plans	70.4	58.1
Indirect Tax Effects	-17.2	-53.4
Deficit		
Mandatory Changes	**-6.7**	**-37.3**
Cumulative Deficit Effect	**-13.8**	**-38.3**

[1] Includes pregnant women and children from 0 to 300 percent of Poverty.

Source: Congressional Budget Office, "A Preliminary Analysis of Senator Mitchell's Health Proposal," Washington, DC, August 9, 1994, Tables 1 and 2.

TABLE A-IV

Effect of Mitchell Proposal on Health Spending

(Billions of dollars)

Baseline

Year	Value of Health Output	Government Spending on Health	Health Insurance	Out-of-Pocket Health Spending	Direct &Tax Subsidies
1995	929	563	343	182	159
1996	1,014	620	374	194	174
1997	1,103	679	407	206	189
1998	1,201	745	441	219	205
1999	1,305	816	478	233	222
2000	1,418	893	519	246	241
2001	1,542	979	562	260	260
2002	1,674	1,072	608	275	281
2003	1,818	1,172	658	291	304
2004	1,974	1,282	713	308	329
2005	2,143	1,402	771	326	355

Mitchell Proposal

1995	929	563	343	182	159
1996	1,006	594	382	195	165
1997	1,140	708	523	198	288
1998	1,235	769	567	210	311
1999	1,323	827	613	220	336
2000	1,423	890	667	231	364
2001	1,537	961	726	244	393
2002	1,655	1,031	791	258	425
2003	1,787	1,110	861	274	458
2004	1,930	1,196	938	291	495
2005	2,084	1,288	1,022	309	535

National Center for Policy Analysis/Fiscal Associates Health Care Model simulation.

TABLE A-IVA

Effect of Mitchell Proposal on Health Spending

(Billions of dollars)

Difference from Baseline

Year	Value of Health Output	Government Spending on Health	Health Insurance	Out-of-Pocket Health Expenditures	Direct &Tax Subsidies
1995	0	0	0	0	0
1996	-8	-25	8	1	-8
1997	37	29	115	-9	99
1998	34	24	126	-10	106
1999	17	11	134	-14	114
2000	5	-3	148	-16	124
2001	-4	-18	164	-17	133
2002	-19	-41	182	-17	143
2003	-31	-62	203	-17	154
2004	-44	-86	225	-17	166
2005	-59	-113	251	-17	179
1995-99	81	39	384	-31	311
2000-05	-101	-288	1,433	-125	1,121

Percent Difference from Baseline

1995	0.0%	0.0%	0.0%	0.0%	0.0%
1996	-0.8	-4.1	2.1	0.5	-4.9
1997	3.4	4.3	28.3	-4.1	52.1
1998	2.8	3.2	28.5	-4.4	51.9
1999	1.3	1.3	28.1	-5.8	51.6
2000	0.4	-0.3	28.4	-6.4	51.3
2001	-0.3	-1.9	29.1	-6.5	51.1
2002	-1.1	-3.8	30.0	-6.2	50.9
2003	-1.7	-5.3	30.8	-5.9	50.7
2004	-2.2	-6.7	31.6	-5.6	50.6
2005	-2.8	-8.1	32.5	-5.3	50.5

National Center for Policy Analysis/Fiscal Associates Health Care Model simulation.

TABLE A-V

Economic Effects of Mitchell Health Care Proposal Without Mandates

(Financial figures are in billions of dollars)

Baseline

Year	Private Output	Non-Health Output	Health Output	Capital Stock	Employment (in thousands)	Labor Income
1995	6,424	5,495	929	16,677	123,306	4,697
1996	6,858	5,844	1,014	17,013	125,040	4,995
1997	7,322	6,219	1,103	17,355	126,798	5,313
1998	7,817	6,616	1,201	17,707	128,581	5,651
1999	8,345	7,039	1,305	18,069	130,390	6,011
2000	8,908	7,489	1,418	18,442	132,223	6,394
2001	9,508	7,966	1,542	18,827	134,083	6,801
2002	10,149	8,474	1,674	19,223	135,968	7,236
2003	10,832	9,014	1,818	19,632	137,880	7,697
2004	11,560	9,587	1,974	20,053	139,819	8,189
2005	12,337	10,194	2,143	20,488	141,785	8,712

Mitchell Proposal

1995	6,424	5,495	929	16,677	123,306	4,697
1996	6,854	5,848	1,006	16,977	125,033	4,995
1997	7,289	6,149	1,140	17,268	126,531	5,289
1998	7,757	6,522	1,235	17,523	128,080	5,611
1999	8,260	6,938	1,323	17,783	129,699	5,960
2000	8,801	7,378	1,423	18,074	131,394	6,332
2001	9,386	7,849	1,537	18,408	133,174	6,733
2002	10,019	8,364	1,655	18,776	135,050	7,167
2003	10,699	8,912	1,787	19,174	136,969	7,632
2004	11,427	9,497	1,930	19,591	138,928	8,128
2005	12,204	10,120	2,084	20,020	140,924	8,658

National Center for Policy Analysis/Fiscal Associates Health Care Model simulation.

TABLE A-VA

Economic Effects of Mitchell Health Care Proposal Without Mandates

(Financial figures are in billions of dollars)

Difference from Baseline

Year	Private Output	Non-Health Output	Health Output	Capital Stock[1]	Employment (in thousands)[2]	Labor Income
1995	0.0	0.0	0.0	0.0	0.0	0.0
1996	-4.0	4.0	-8.0	-36.0	-6.9	-0.5
1997	-32.7	-69.8	37.1	-86.9	-267.7	-24.0
1998	-59.9	-94.1	34.1	-184.5	-501.1	-39.8
1999	-84.1	-101.5	17.4	-285.8	-690.4	-51.3
2000	-106.3	-111.5	5.2	-368.6	-829.3	-62.0
2001	-122.0	-117.5	-4.5	-418.4	-908.6	-68.5
2002	-129.2	-110.3	-18.9	-446.8	-918.2	-68.2
2003	-132.7	-101.7	-31.0	-457.7	-911.0	-65.8
2004	-133.6	-89.5	-44.2	-462.2	-890.7	-61.1
2005	-133.0	-73.9	-59.1	-467.4	-860.6	-54.4
1995-99	-180.8	-261.3	80.6			-115.6
2000-05	-756.9	-604.4	-152.5			-380.0

Percent Difference from Baseline

1995	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
1996	-0.1%	0.1%	-0.8%	-0.2%	0.0%	0.0%
1997	-0.4%	-1.1%	3.4%	-0.5%	-0.2%	-0.5%
1998	-0.8%	-1.4%	2.8%	-1.0%	-0.4%	-0.7%
1999	-1.0%	-1.4%	1.3%	-1.6%	-0.5%	-0.9%
2000	-1.2%	-1.5%	0.4%	-2.0%	-0.6%	-1.0%
2001	-1.3%	-1.5%	-0.3%	-2.2%	-0.7%	-1.0%
2002	-1.3%	-1.3%	-1.1%	-2.3%	-0.7%	-0.9%
2003	-1.2%	-1.1%	-1.7%	-2.3%	-0.7%	-0.9%
2004	-1.2%	-0.9%	-2.2%	-2.3%	-0.6%	-0.7%
2005	-1.1%	-0.7%	-2.8%	-2.3%	-0.6%	-0.6%

[1] Amounts are cumulative.

[2] Each job represents 2,040 labor hours annually. Amounts are cumulative.

National Center for Policy Analysis/Fiscal Associates Health Care Model simulation.

Table A-VI

Impact of Mitchell Proposal on Federal Budget

(Billions of dollars)

Year	Direct Spending	Insurance Subsidies	Other Tax Subsidies	Other New Spending	Net Taxes	Deficit Impact
1996	-11.6	0.2	-1.6	4.6	1.0	-9.4
1997	-62.7	81.1	1.4	4.9	-5.9	30.6
1998	-72.2	87.5	1.3	8.2	-12.4	37.2
1999	-89.3	95.9	0.1	11.5	-18.2	36.4
2000	-107.5	104.0	-0.6	15.7	-24.6	36.1
2001	-127.6	112.1	-1.4	17.4	-29.4	30.1
2002	-150.4	120.9	-2.4	18.2	-31.8	18.1
2003	-174.6	130.1	-3.3	20.7	-33.0	5.9
2004	-201.6	140.0	-4.3	24.2	-33.4	-8.2
2005	-232.1	150.7	-5.3	28.4	-33.3	-24.9
1996 -2005	**-1,229.5**	**1,022.6**	**-16.0**	**153.7**	**-220.8**	**151.7**

TABLE A-VII

Impact of Mitchell Proposal on State and Local Budgets

((Billions of dollars)

Year	Direct Spending	Other Tax Subsidies	Other New Spending	Net Taxes	Deficit Impact
1996	-3.3	-0.2	0.4	0.7	-3.7
1997	4.6	0.1	3.7	-1.2	9.7
1998	2.8	0.1	5.8	-3.8	12.5
1999	-0.9	-0.1	6.7	-6.9	12.6
2000	-4.2	-0.1	7.5	-10.6	13.8
2001	-6.8	-0.2	8.3	-13.3	14.5
2002	-13.7	-0.4	8.9	-14.3	9.1
2003	-18.8	-0.5	9.4	-14.5	4.7
2004	-24.4	-0.6	10.0	-14.1	-0.8
2005	-30.7	-0.7	10.6	-13.5	-7.3
1996 -2005	**-95.3**	**-2.5**	**71.3**	**-91.4**	**64.9**

National Center for Policy Analysis/Fiscal Associates Health Care Model simulation.

TABLE A-VIII

Impact of Mitchell Proposal on Household Spending

(Billions of dollars)

Year	Change in Out-of-Pocket Costs	Change in Insurance Costs, Net	Change in Net Health Care Costs	All Spending Changes	Other Consumption Changes	Change in Value of Health Care	Change in Value of Consumption
1996	0.9	17.6	18.4	-5.8	4.0	-8.0	-4.0
1997	-8.1	32.0	23.9	-24.4	-69.8	37.1	-32.7
1998	-9.2	36.5	27.3	-41.8	-94.1	34.1	-59.9
1999	-12.8	37.8	25.0	-56.6	-101.5	17.4	-84.1
2000	-14.9	43.6	28.7	-68.2	-111.5	5.2	-106.3
2001	-15.9	52.3	36.4	-75.9	-117.5	-4.5	-122.0
2002	-16.1	63.2	47.1	-79.8	-110.3	-18.9	-129.2
2003	-16.4	75.3	58.9	-82.1	-101.7	-31.0	-132.7
2004	-16.5	89.3	72.9	-83.1	-89.5	-44.2	-133.6
2005	-16.4	105.3	88.8	-83.6	-73.9	-59.1	-133.0
1996 -2005	**-125.5**	**552.9**	**427.4**	**-601.2**	**-865.7**	**-72.0**	**-937.7**

National Center for Policy Analysis/Fiscal Associates Health Care Model simulation.

About the Authors

Aldona Robbins, an NCPA Senior Fellow and Vice President of Fiscal Associates, has extensive experience with public and private retirement programs. Dr. Robbins served as senior economist in the Office of Economic Policy, U.S. Department of the Treasury from 1979 to 1985 and has developed a model to project Social Security benefits and tax revenues. Recent publications include NCPA Reports entitled "What A Canadian-Style Health Care System Would Cost U.S. Employers and Employees" and "Taxing the Savings of Elderly Americans"; an NCPA and Institute for Policy Innovation Report entitled "Paying People Not To Work: The Economic Cost of the Social Security Retirement Earnings Limit"; a book entitled *The ABCs of Social Security* , published by the Institute for Research on the Economics of Taxation Economic Report; and an article entitled "Encouraging Private Provision for Long-Term Care" in *Compensation and Benefits Management*. Her articles on Individual Retirement Accounts and Medicare have appeared in the *Wall Street Journal.*

Gary Robbins is an NCPA Senior Fellow and President of Fiscal Associates. Mr. Robbins has developed a general equilibrium model of the U.S. economy that specifically incorporates the effects of taxes and government spending. Before joining the private sector, he was Chief of the Applied Econometrics Staff at the U.S. Treasury Department from 1982 to 1985, Assistant to the Under Secretary for Tax and Economic Affairs from 1981 to 1982, and Assistant to the Director of the Office of Tax Analysis from 1976 to 1981. Recent publications include NCPA Reports entitled "Taxes, Deficits and the Current Recession," "A Pro-Growth Budget Strategy: Vision for the 1990s" and "Elderly Taxpayers and the Capital Gains Tax Debate"; an IPI Report entitled "Will Raising Taxes Reduce the Deficit?"; and a report for the U.S. Chamber of Commerce entitled "Adding to the S&L Solution: A Case for Lower Capital Gains Taxes." His articles on various tax policy issues have appeared in the *Wall Street Journal.*

The National Center for Policy Analysis

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NCPA forecasts show that repeal of the Social Security earnings test would cause no loss of federal revenue, that a capital gains tax cut would increase federal revenue and that the federal government gets virtually all the money back from the current child care tax credit. These forecasts are an alternative to the forecasts of the Congressional Budget Office and the Joint Committee on Taxation and are frequently used by Republicans and Democrats in Congress. The NCPA also has produced a first-of-its-kind, pro-free-enterprise health care task force report, presenting the views of 40 representatives of think tanks and research institutes.