



A FEDERAL TAX CREDIT TO ENCOURAGE EMPLOYERS
TO OFFER HEALTH COVERAGE

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EXECUTIVE SUMMARY

Many firms that employ low-wage workers cannot afford to offer an employee health plan, and many of the uninsured work for such firms. This partly explains why so many Americans are uninsured, since most low-wage workers and their families are also ineligible for public programs such as Medicaid and cannot afford individual coverage. A system of federal tax credits to provide incentives to businesses that employ low-wage workers to help pay for insurance would enable more firms to offer group health insurance. Such a system could be administered through the IRS. Since it would require no new bureaucracy and no direct budgetary appropriation, its political feasibility would be enhanced. However, it might be expensive. Unless the employer tax credits are set at levels high enough to cover a large share of the cost of insurance, the take-up rate among both employers and employees would be low.

The program we propose would be targeted to low-wage firms, those in which average wages are less than \$10 per hour, but the premium subsidy would be graduated so that the credit is largest for firms with the lowest average wages. For example, the maximum credit, equal to half the value of a "Standard" benefit package, would go to firms with average wages below \$7 per hour. Firms with somewhat higher wages would get somewhat less, say 40 percent; and firms nearing \$10 per hour would get the minimum credit of 30 percent.

All low-wage firms, including those already offering health insurance, would be eligible for the tax credit. Although this feature makes the program more expensive, it avoids the inequity of providing premium assistance to firms that have in the past failed to provide coverage while not assisting similarly situated firms that have offered coverage. It may also reduce the extent of underinsurance by improving the benefits or lowering the cost borne by low-wage workers. It also avoids the administrative complexities of trying to prevent "crowd-out."

The value of the tax credit would be uniform across the nation but would be adjusted upward as health care costs rise. The Standard benefit package could include hospital and emergency care, x-rays, lab work, prescription drugs, physician visits, and mental health services.

Employers getting the credit would be required to contribute toward the health insurance premium an amount equal to 50 percent of the actuarial value of this Standard benefit package. But employers could offer any benefit package that they thought would

best meet their employees' needs. Although some employers would voluntarily contribute more than the required 50 percent, firms eligible for the full 50 percent tax credit would not need to bear any net cost. Employees would obviously pay the difference. For many low-wage employees, this cost could be unaffordable. Thus, the effectiveness of employer credits would be enhanced if combined with individual credits for the lowest-wage workers.

Firms are far less likely to establish and maintain employee health benefits if they know that the premium subsidy is only temporary. For this reason, the tax credit would be permanent (so long as the employer meets the wage test). To make it easier for employers to pay premiums as they come due every month, employers could receive "advance" credits against quarterly taxes or perhaps even cash payments rather than having to wait until tax payment time to be credited with the appropriate amount.

Employers receiving the credit would be required to offer coverage on an equal basis to all full-time employees. They would have the option of receiving a credit for benefits offered to seasonal and part-time workers.

Because most eligible employers would be buying coverage in the small-group market, states or the federal government may need to take further steps to improve the performance of this market. In particular, some states allow such large variations in premium rates that some higher-risk groups may find premiums unaffordable even with the tax credits. Forms of collective purchasing could also help, especially if firms receiving the credit were required to buy coverage through collective purchasing arrangements. This would help these entities to become large enough to realize savings in marketing and administration costs.

Relative advantages of the tax-credit approach are its administrative simplicity and political palatability, its ability to target needy people, and its enhancement of group-based coverage. On the other hand, employer tax credits would not reach all uninsured people and would add another layer of complexity on an already complex subsidy system.

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The problem of the uninsured is largely a problem of working people. More than four of five people who lack health insurance live in households with at least one worker. Most work for employers who do not provide health coverage, yet they and their families are not eligible for public programs. One way to extend health coverage to such people is for the federal government to offer tax credits to employers who contribute to the cost of their employees' health insurance.

Many employers do not provide health coverage because they believe it is too expensive. This is particularly true of small firms. In 1999, only 55 percent of firms with three to ten workers offered health coverage, whereas among firms with 50 or more workers, more than 90 percent did so. Among small firms that do not offer coverage, 68 percent cite the high cost of premiums as a major reason.¹

Although small firms are particularly likely not to offer coverage, not all of the uninsured work for small firms. A distinctive feature of the strategy presented in this paper is that the tax credits for employers would assist all firms that employ primarily lower-wage workers, not just small firms. Thus, assistance would be (indirectly) targeted to workers who would have difficulty affording health insurance on their own, regardless of the source of their employment. A cap on the tax credit (premium subsidy) for employers with average wages above a specified level would also screen out smaller firms comprised primarily of high-earning professionals (for example, law firms).

Another advantage of the tax credit approach is that it would work through the existing federal tax system; no new programs or bureaucracies would need to be established. Furthermore, if the program is properly designed, the cost of the subsidy could be controlled.

The principal disadvantage of this approach, which it shares with other approaches involving tax credits as incentives to offer health insurance, is cost. To be effective, the credit (and premium subsidy) has to be substantial. Unless the employer tax credits are set at rather high levels and thus cover a large portion of the cost of health coverage, the "take-up rate" among employers will be quite low. Even when employers do decide to offer coverage, unless the tax credit is sufficient to induce employers to contribute a substantial amount toward the premium, employees may not take up the employer's offer of coverage. Yet a credit set high enough to overcome this problem could be expensive,

and the cost will be higher if all employers meeting the wage-level criterion are eligible, including those already offering and funding coverage.

The remainder of this paper describes how an employer tax credit could be designed to encourage more employers to offer coverage without being so costly as to make the idea politically infeasible. Although we confine our discussion to *employer* tax credits, it is worth noting that the approach is compatible with extending tax credits to low-wage *employees* as well. Since employer-sponsored coverage has significant advantages over individually purchased coverage, it is important to give employers inducements to offer coverage to their employees rather than simply to extend subsidies to employees so they can buy coverage in the individual market. Offering subsidies to both low-wage employers and their employees would likely increase the take-up rate substantially.

BACKGROUND

The effectiveness of a health insurance tax credit depends in part on the willingness of employers to offer coverage when they did not previously do so. That will depend, in turn, on how responsive employers are to a reduction in the price of coverage, which is the effect of the tax credit. Several studies have examined this question, using a variety of research methods. One group of studies uses variations in tax rates across states to determine the impact of after-tax prices on small firms' willingness to offer health coverage. Estimates of the price elasticity in this group of studies ranged from -0.63 to -2.9 , indicating a strong response by employers to price changes (in other words, if price declines by 1 percent, the quantity of health insurance purchased should increase by somewhere between slightly less than 1 percent to nearly 3 percent).²

Actual experience yields a less optimistic view of the likely success of using tax credits as subsidies to induce employers to offer coverage. In the late 1980s and early 1990s, several states began to experiment with both tax credits and direct premium payments for employers who newly offered health coverage.³ The tax credits were generally quite small (for example, \$25 to \$35 per employee per month) and were not well publicized. The take-up rate by employers was very low, with most sites achieving less than 10 percent participation rates after more than a year in operation. Kansas, Kentucky, and Oregon used tax credits to try to induce companies to offer health coverage, generally with very limited success. But Oregon's program did manage to sign up more than 13,000 employers, affecting about 43,000 people.

Over this same period, the Robert Wood Johnson Foundation ran a \$6 million demonstration project enabling states to design and offer direct premium subsidies for

employers offering health insurance. While the experience varied considerably over ten sites, in general there was only a tepid response from the business community to the new subsidies, even though the projects effectively lowered premiums for employers by 25 to 40 percent. In Florida, for example, a demonstration project that used a state purchasing cooperative to lower premiums for firms with fewer than 20 workers offering coverage for the first time enrolled only 1.7 to 5.0 percent of the target group of firms in five participating cities.

More recently, New York initiated a direct premium assistance program in 1997 that sparked considerable interest. In little over a year, some 1,100 firms signed up, and a waiting list developed because only \$6 million had been appropriated for the program. The program is being phased out, however. It will be replaced by a larger program that will provide state-sponsored stop-loss coverage to health plans in order to reduce premiums—rather than provide direct premium assistance to small employers.

A review of these initiatives leads to the conclusion that if tax subsidies for employers are to have a noticeable impact on health coverage, they will need to include features that make them more costly than the pilot projects tried to date. The value of the credit needs to be substantial. To hold down costs and limit the inequities for firms that were already offering coverage, many states offered the subsidy for only a limited number of years. Employers reacted negatively to the “pilot” nature of the projects, fearing that they would start offering coverage with the help of the subsidy but then quickly be left to finance the full cost. Finally, the experience to date suggests that a major effort will have to be made to publicize the subsidies. Employers were often simply unaware of them.

THE TARGET POPULATION

The target population for the tax subsidy is firms with wages below a defined level. For the purpose of this analysis, we set the average-wage rate cutoff at \$10 an hour. For a full-time worker, this translates into an annual salary of about \$20,000 a year. Since the average family has 1.6 workers, some families with incomes in excess of \$20,000 per year will benefit from the subsidy. We propose to extend eligibility to all low-wage employers, regardless of whether or not they currently offer coverage.

KEY DESIGN FEATURES

Several important design features increase the likelihood that this employer tax credit strategy will succeed in substantially reducing the number of working uninsured while containing the cost of the program:

1. The credit is available only to low-wage firms—those with average wage levels below \$10 per hour—and is graduated so that the amount of the credit is largest for firms with the lowest average wage.
2. The credit is permanent, available as long as the firm meets the low-wage test of eligibility.
3. The tax credit is available to all low-wage firms, not just to those not currently offering coverage.
4. The credit is a large enough proportion of the cost of health coverage to induce a meaningful take-up rate among employers and their employees.
5. The tax credit is set at a fixed-dollar amount.
6. The credit is tied to the price of a “Standard” cost-effective benefit package.
7. The credit is uniform across the nation.
8. The credit is updated annually by repricing the Standard benefit package.
9. Firms must contribute toward the premium an amount equal to at least 50 percent of the cost of the Standard benefit package.
10. Employers taking the credit must offer coverage on the same basis to all full-time workers; coverage offered to part-time and temporary workers, though not mandatory, qualifies for the credit.
11. The credit amount is different for single and family coverage.
12. Firms are required to show proof of the amount they contribute to coverage when they file their income taxes and claim the credit.
13. Firms can claim the credit in installments rather than waiting until they file their annual income taxes, and the credit is refundable if the credit amount exceeds the firm’s tax liability.

These basic design features are discussed below.

Targeting the Credit to Lower-Wage Firms

A unique feature of the proposed tax credit is that it is targeted to lower-wage firms. The credits would apply only to firms with average wage levels below \$10 per hour, and the amount of the subsidy would increase as average wages fall below that level. The maximum credit—equal to 50 percent of the cost of the Standard benefit package—would apply to firms with average wages below \$7.00 per hour. Firms with average wages between \$7.00 and \$8.50 would get 40 percent of cost of the Standard benefit package, and firms with average wages between \$8.50 and \$10.00 would get 30 percent of this amount. The hourly wage rates used to determine eligibility would be updated periodically, using the Consumer Price Index, to ensure that the wage-level cutoffs represent constant purchasing power and are not eroded by inflation.

There are compelling reasons to target the subsidies to low-wage firms. First, low-wage firms are much more likely to be non-offerers of health coverage. For example, a recent study by the RAND Corporation found that for low-wage firms with fewer than 50 workers, only 17 percent offered health coverage compared with 47 percent of higher-wage firms of the same size.⁴ When group coverage is not available, these workers are also less likely to be able to do the “next best thing”—purchase coverage in the individual market. Such coverage is estimated to cost about 25 to 40 percent more than group coverage.⁵

Second, targeting low-wage firms also ensures that subsidies are not given to groups of high-earning professionals who could afford unsubsidized coverage. Besides conforming to widely accepted standards of fairness, implementation of this provision reduces the cost of the program to the federal government.

One drawback of this approach is that it adds a layer of administrative complexity to the system because firms have to collect and report average wage levels. Most companies, however, should have such information readily available.

Another concern involves inequities related to “notch” problems: firms with wage levels just above the cutoff point for eligibility receive no assistance even though their circumstances are essentially the same as firms just below the cutoff point. A gradual phasing out of the subsidy for firms with wage levels above the initial cutoff point can reduce such inequities. Not only is the approach more equitable, but it also gives employers less reason to worry that granting a wage increase would produce a large reduction in the firm’s health insurance subsidy. However, making the subsidy graduated adds to administrative complexity.

An alternative to using firms' average wage levels to target the subsidy is using the *proportion* of workers with wages below a threshold level. For example, a firm's eligibility for the tax credit could be contingent upon 60 percent of the employees earning less than \$10 per hour. This alternative might improve the target efficiency of the employer tax credits, because it would screen in some companies in which most of the workers receive low wages but the average wage is above the threshold. An example would be a small company in which the president, and perhaps one or two senior managers, earned high salaries that pull up the average wage above \$10 per hour. But, of course, this alternative would also exclude some firms that appropriately could be subsidized, such as those with an average wage below \$10 per hour but where the percentage of employees earning \$10 per hour is just below the cutoff level (for instance, 59 percent in our illustration above). Either approach is likely to exclude some firms that should be eligible. A third alternative would be to combine the two approaches, allowing firms to qualify either if the average wage was below a specified level or if the proportion of low-wage workers in the employer's workforce fell below a specified proportion.

Credits Are Not Temporary

The tax credit described here would be permanent, not temporary. An employer would qualify for the credit as long as the average wage paid to employees fell below the cutoff point. The most important reason for making the premium assistance permanent is to increase the "take-up" and the "stay-put" rates. The evidence cited earlier makes it clear that many employers are reluctant to take advantage of subsidies if they know they are temporary. Apparently, employers do not want, or believe that they would not be able, to bear the full cost when the subsidy is reduced or eliminated; and they would rather not provide coverage at all than provide it for a while and then drop it. Furthermore, if the subsidy were temporary, some of the employers who would take up coverage would later drop it when the subsidy expires. But if the subsidy were permanent, most of these employers would continue to offer coverage.

The disadvantage of this approach compared to a temporary subsidy is the budgetary cost. When subsidies are temporary, the cost is obviously lower—though it is important to recall that for firms with rising real wage levels, the amount of the subsidy will decrease over time and may disappear.

All Low-Wage Firms Eligible

A second feature of this proposal distinguishes it from many other incremental approaches for extending coverage to the uninsured: the subsidy is available to firms that already offer coverage, as well as to those that do not. Making all low-wage firms eligible is a corollary

of the decision to make subsidies permanent. Unless subsidies are available to firms already offering health coverage, these firms would be treated inequitably.

Approaches that restrict eligibility to firms not offering coverage differentially treats firms that are in all relevant respects essentially the same, giving subsidies to some but not to others. The firms already offering coverage would be penalized. According to economic theory, in order to attract an adequate supply of labor, firms in a labor market must pay comparable workers essentially the same total compensation (defined as cash wages plus benefits). Thus, if one firm in an industry pays for health coverage and another does not, then the non-offering firm must pay higher cash wages or increase the generosity of other employee benefits to offset the absence of health benefits. If the firm not offering health coverage becomes eligible for the tax credit and decides to offer coverage, this firm will have a competitive advantage over firms already offering coverage, which are not eligible for the subsidy. The firm newly offering coverage is being subsidized by the federal government in the amount of the tax credit. This firm will thus be able to pay its workers higher cash wages and thereby attract more productive workers; or, alternatively, it will be able to pay the same total compensation but use the savings to invest in some other part of the business or to increase profits. The subsidized firms (those receiving the tax credit) gain relative to competing firms that are ineligible for the tax credit. Firms that began contributing to health insurance before a tax credit was available could legitimately complain that they were being penalized for having made the decision to provide coverage. Many firms of this size are marginally profitable, so that giving an advantage to newly insuring firms relative to those already providing coverage might cause some of the latter to go under. Such inequities might be tolerable if the subsidies were phased out after five years or so, but they are not justifiable if the subsidy is permanent.

The obvious disadvantage of this all-inclusive approach is the higher budgetary cost: some firms that do not need the inducement of a subsidy to get them to offer coverage will now receive subsidies. It could be argued that the money that goes to these firms is “wasted,” in the sense that it does not buy any reduction in the number of uninsured. We acknowledge the criticism, but we think the argument is not compelling, not only because of the inequities just examined, but for other reasons as well.

First, when subsidies are confined to employers not offering coverage, a good deal of administrative effort and expense has to be devoted to preventing “crowd out.” The system has to be carefully designed to minimize incentives for employers to drop coverage so that they can become eligible for the subsidy, and safeguards have to be in place to

ensure that only eligible employers and employees get subsidies. Making all low-wage employers eligible eliminates these significant administrative burdens and expenses.

Second, although allowing employers that already offer coverage to receive the tax credit adds to the budgetary cost, the total real *resource* cost to society—in terms of additional medical services utilized—would be essentially the same whether or not currently offering firms are eligible for the subsidy: only newly insured employees would be consuming additional medical resources. The previously covered employees were presumably already consuming a full range of medical services. The real cost to society is the other uses to which these resources might be put, but that is the same in either case. The difference between the two options is not the cost, but whether the cost appears in public or private budgets—and that does, of course, have important political implications. To the extent that employer already offering coverage, used the new credits to enhance benefits or maintain or lower employee premium shares, this feature could also help reduce the extent of “under-insurance” among low wage employees or moderate financial burdens.

Tax Credit Large Enough to Induce an Acceptable Take-Up Rate

The tax credit needs to be large enough to cause a significant proportion of non-offering employers to begin offering health coverage. For reasons about to be explained, we think that the credit should be about half the cost of reasonably comprehensive coverage.

As noted earlier, past experience with small tax credits has been dismal. Employers have largely disregarded the incentives. The cost of health coverage is particularly high for smaller firms, and they are often the least able to pay the high cost because many are on the margin of financial solvency. While some may be induced to participate by a small tax credit, most will require that the government pick up a major share.

A 1991 Harris poll of small employers (those with fewer than 50 workers) not offering coverage found that only 31 percent indicated that they were “very likely” to purchase insurance if the government subsidized one-third of the cost. The proportion that would *actually* purchase coverage with such a subsidy is deemed to be much lower, since employers tend to overstate their intentions in such surveys.⁶

The subsidy not only has to be large enough to induce employers to participate; it also has to be large enough that the employer’s premium contribution is sufficient to induce *employees* to participate. For this reason, it is worth examining the evidence on how large a tax credit it would take to induce employees to participate in employer-

sponsored coverage. A recent study by Professors Mark Pauly and Bradley Herring concludes that for low-income workers and their dependents below 300 percent of the poverty line, where the uninsured are disproportionately found, “substantial reductions in the number of uninsured will require credits in the range of a third to a half of the individual insurance premiums, with credits needed to be even greater than 50 percent for families with incomes at the bottom of this range.”⁷ Presumably, employer contributions of approximately the same magnitude would also induce employees to accept the employer-subsidized coverage.

In light of the discouraging experience with small credits, it seems likely that a credit that equals or approaches about half the cost of a rather comprehensive health plan would be needed. Setting the credit too low as a proportion of the premium, or pegging this proportion to a very basic plan that firms and employees would not want to select, can lead to a low take-up rate and therefore a minimal effect on the number of uninsured.

Under the proposed design, an employer eligible for the full subsidy could contribute 50 percent of the premium and have that amount completely reimbursed through the tax credit. The employer’s net costs of providing coverage would be zero. Employees would be required to contribute the remaining 50 percent. A 50 percent contribution could be burdensome, however, for low-wage workers. It is hoped that with such a generous subsidy, many employers would contribute an amount above the value of the subsidy, thereby easing the burden on employees. If this did not occur, however, an alternative would be to *require* the employer to contribute an additional portion (25 percent, for example) in order to receive the tax credit. In effect, employers and employees would be splitting the remaining premium cost. This requirement on employers would force some firms to contribute more of the premium cost than they would otherwise. Although the extra amount would be a deductible business expense, the requirement would lower employers’ take-up rate, at least to some degree. At the same time, it would *increase* the take-up rate for *workers* in firms that do take the credit. Without this requirement, more firms would take the credit, but a smaller proportion of workers would enroll in health plans.

Credits to employers could also be accompanied with direct premium assistance for low wage employees to cover the employee share of the premium. These could be in the form of tax credits or direct premium assistance programs. (See Merlis, 2000 for a discussion of credits to employees for premium shares.⁸)

Another way to ease the burden on low-wage workers who must contribute toward premiums is to coordinate financial assistance from other programs, such as Medicaid and the Children's Health Insurance Program (CHIP). This is discussed in detail below (see *Interacting with Other Programs*).

Fixed-Dollar Credit

A fixed-dollar credit amount provides firms with incentives to purchase reasonably priced, high-value health plans. The lower the premium for the plans selected the higher proportion of the cost that will be defrayed by the credit. Because the subsidy is limited, employers and employees also have incentives to choose plans that offer a high level of benefits (in terms of quality of care, levels of service, covered services, etc.) relative to premium cost.

An open-ended subsidy, in contrast, would provide an incentive for firms to "over-purchase" insurance. The incentive would be similar to that embedded in the current tax exclusion, which permits workers to not count as taxable income the full value of their employers' contribution to health coverage.

The fixed-dollar subsidy, unlike an open-ended one, would help limit the cost to the federal government.

Credit Tied to the Price of a Defined "Standard" Benefit Package

The tax credit for employers will be set as a fixed proportion of the nationwide average cost of an efficiently provided "Standard" benefit package. Coverage should include such vital services as hospital care, emergency department care, physician visits, preventive services, x-rays, laboratory work, prescription drugs, and mental health services. The levels of patient cost-sharing should be reasonable. The price would be determined by looking at the cost when these services are provided by an efficient health plan with appropriate controls over utilization and cost-effective relationships with providers. The purpose of choosing this approach is to keep the budgetary cost down and to provide incentives for employers to select efficient health plans to offer their workers.

The specification of a benefit package would be used only to set the level of the subsidy. Employers would *not* be required to offer coverage that includes the minimum benefits (though they would be required to comply with any state-mandated benefits and to make a minimum contribution, as explained below). An argument could be made for requiring coverage that includes specified minimum benefits, to ensure minimum levels of coverage. However, defining a required benefit package is extraordinarily controversial. Moreover, as technologies and patterns of medical practice evolve, the content of a

minimum benefit package should constantly be redefined. We think it best to avoid those complications.

Uniform Credit Nationwide

The amount of the tax credit would be uniform across the nation. A case could be made for varying the credit by geographic area because health care premiums vary sharply from region to region. With a uniform credit level pegged to a national average, the purchasing power of employers in regions with high health care costs will be less than intended, while employers in low-cost regions will be overcompensated. However, this consideration is outweighed by the need to keep the tax-credit plan workable and administratively feasible. The U.S. Treasury Department could be expected to vigorously oppose any provision in this plan that called for regional variation in the subsidy level. The Treasury Department would rightly argue that all other tax credits (for example, EITC, child care) are uniform across the nation.

In addition, raising the value of the tax credit in areas of the country with relatively high health care costs might send the wrong signal. The federal government would be seen as underwriting inefficient care delivery in high-cost regions, which goes against the grain of building cost discipline into the health care system. Payers with a national perspective are asking why various measures of utilization (for example, hospital admission rates, hospital bed days per 1,000 population, or surgery rates for certain high-cost procedures) are much higher in some parts of the country than in others. The federal government probably should not undercut this pressure by propping up higher costs with higher subsidies.

The credit would also not be adjusted for other characteristics of the firm's workforce that could have a predictable effect on its health-coverage outlays, such as the average age of workers, their health status, and their past medical-claims experience. Although a case could be made for such adjustments to assist employers who have an older or less healthy workforce, the need to keep the plan administratively simple argues against adopting such a provision.

Updating the Credit Amount

To ensure that the purchasing power of the credit does not dwindle over time because of inflation, the defined benefit package would be repriced from year to year. At the same time, any necessary changes in the composition of the package would be made. Again, the price would be what an *efficient*, high-quality health plan would charge for the defined set of services. The advantage of this approach to repricing is that it would ensure that the

subsidy would stay equal to some fixed proportion of an appropriate benefit package as medical care costs increase and as technological change and changing social values redefine what should be included in a reasonably comprehensive benefit package. Repricing on this basis does involve a degree of complexity that some alternatives would avoid.

The principal alternative is to update the credit annually in line with *general inflation* in the economy. If past experience is any guide, this would mean that the real purchasing power of the credit would rise at a slower rate compared to our preferred approach. The argument for this approach has to do with cost discipline. Just as varying the credit by region may serve to prop up higher health costs in some areas, adjusting the credit upward in line with health costs could contribute to the ongoing gap between the escalation in health care spending and that in the rest of the economy. By updating for economy-wide inflation, the federal government would keep the credits from eroding rapidly but at the same time would apply some pressure to bring health care spending increases under control. However, on balance, we do not find this argument persuasive. The kinds of employers who would take advantage of the tax credit are generally small and marginally profitable and would have little power to influence the rate of cost escalation for health care services. Moreover, if health care cost escalation were to substantially outpace general inflation, after a few years the purchasing power of the credit would be so eroded that the subsidy would be insufficient to induce many employers and employees to take coverage.

Minimum Contribution Level

Firms must contribute at least 50 percent of the cost of the “Standard” benefit package. For firms receiving the full tax credit, this requirement means that they would not be required to make any *net* (after-subsidy) contribution. But firms with wage levels too high to qualify for the full credit would have to make a net contribution. This feature is consistent with the notion that subsidies are tied to ability to pay.

The main purpose of this requirement is to ensure that employees of all participating firms, including those not receiving the full tax credit, benefit from a substantial employer contribution, thereby making coverage more affordable for employees and increasing the employee take-up rate. It is also worth noting that some health plans that sell coverage to small employers require that employers contribute at least 50 percent of the premium. Insurers impose this requirement because they want to encourage broader participation in the group and thereby reduce the likelihood that the only people who buy coverage are those who know they are likely to need expensive medical services.

The disadvantage of requiring a minimum premium contribution of 50 percent is that it will deter some employers who are not eligible for the full 50 percent subsidy from accepting the tax credit and offering coverage. In the absence of the requirement, some of these employers might be willing to offer coverage if there is no net cost to them, at least initially. And some of those might, after having experience providing coverage, be willing to use their own resources to continue coverage. Such employers will be lost from the system.

Note that we do not propose that employers be required to buy coverage that includes any minimum benefit package. We do, however, require a substantial premium contribution, enough to pay 50 percent of the cost of such a benefit package. But after that we let the market operate, based on the assumption that employers and their employees are in the best position to determine what kind of coverage best meets employees' needs. For example, they might decide to use the 50 percent amount to cover 80 percent of a somewhat less comprehensive set of benefits.

We do not propose that employers be required to make a contribution toward dependent coverage (though they would be required to *offer* dependent coverage). Although requiring a contribution to dependent coverage would certainly help to reduce the number of uninsured, we decided against such a mandate because it would almost surely reduce the take-up rate among employers. Moreover, working spouses who are employed by low-wage firms may also become eligible for coverage when their employer accepts the tax credit, and the family's children may be eligible for some other subsidized program, such as CHIP.

Minimum Requirements Regarding Who Is Covered

Employers would be required to offer coverage on the same terms to all full-time employees, defined as those working 32 hours or more per week. Employers could impose a waiting period before extending coverage to newly hired workers, but the maximum waiting period would be six months.

In a firm with a preponderance of low-wage workers but also a few high-wage workers, it is possible that the high-wage workers would accept the employer's offer but most low-wage workers would not. While such a result would be inefficient in terms of targeting the subsidy to a population in need, it is a price worth paying and, in any case, will probably not be a frequent occurrence.

Employers could, but would not be required to, cover part-time, temporary, and seasonal employees. They would receive the full tax credit for covering such workers as an incentive to include this growing segment of the workforce. There could be a requirement that the tax credit is conditional on equitable participation of workers across different wage levels. Of course, the credit would apply only to premiums actually paid during the year. The credit would thus be based on the yearly average of the per-member per-month premium payment. In calculating average wage levels, the wages of temporary and part-time workers would be included on a pro rata basis.

Firms could not include in the wage calculation amounts paid to leased or contract workers even though they work at the company's work site. Self-employed consultants and contract workers could receive the tax credits as separate business entities, however, if they meet the wage criteria and if their state recognizes businesses with one employer as eligible for "group" coverage (further discussed below).

A minimum participation requirement might be set. For example, at least 50 percent of eligible workers might need to enroll in the health plan in order for a firm to receive the tax credit. An advantage of such a requirement is that the employer might work harder to encourage workers to participate, possibly contributing more toward the premium. Also, greater participation would help spread risk over a larger group and reduce adverse selection. Health coverage for groups frequently contains minimum participation rules for this reason. However, if some workers refuse to participate, they could deprive others of the chance to have health coverage. Therefore, the tax credit we propose does not contain an explicit minimum participation requirement, but rather leaves such guidelines to existing insurance rules.

Different Credit for Workers Purchasing Single and Family Coverage

The tax credit amount would vary for single and family coverage, rather than being a single amount based on a blend of single and family premiums. This removes the incentive for firms to favor hiring single workers, or those whose spouses and children are covered under the plans of the spouse's employer. With a blended rate, firms hiring single workers or those with spousal coverage would receive a windfall gain. Firms would have to report the number of employees with single versus family coverage, but this should not create a large administrative burden.

In practice, health plans often have at least three or four rates—for example, single coverage, worker and spouse, parent and children (no spouse), and full family coverage (two adults and children). But so many variations may be too complicated. The two-rate

structure seems a fair compromise, and the family policy rate could be tied to a benefit package cost that is a blend of different types of family coverage.

Firms could take the credit only for workers who enroll in the company's plan. The total credit could not be greater than the amount the firm contributes toward premiums. Thus, if a worker is enrolled in a spouse's plan, the spouse's employer will get the credit but not the worker's employer. This would avoid double crediting.

Proof of Purchase

Firms would be required to demonstrate to the IRS that they purchase insurance or self-fund coverage that meets the requirements of the program. They would also need to document the amount they pay for coverage, and prove that they are making regular, periodic payments equal to or exceeding half of the premium cost of the Standard benefit package. Employers would have to document the annual average of the per-member per-month premium payment for both single and family coverage.

While a firm is receiving the tax credit, it cannot deduct the amount of the subsidy as a business expense. That is, it can only claim as a business expense deduction the *net* (after-tax credit) contribution to health coverage.

Overcoming Business Cash-Flow Problems and Changing Numbers of Workers

Some employers may have difficulty paying for coverage throughout the year and waiting to be reimbursed until well into the following year when they calculate their taxes. A system of advance credits or payments by the government might address this cash-flow problem. For example, employers filing quarterly tax returns could be permitted to reduce their tax liability each quarter to reflect the expected value of the tax credit. The credit could also be made refundable, so that companies that have little or no tax liability would receive a net payment.

Advance payments would alleviate cash-flow problems for many small firms. However, this approach might create some administrative complexity involving the year-end reconciliation between advance payments and the actual amount for which the firm turns out to be eligible. For example, a firm may claim advance payments using calculations based on 20 workers. If the firm downsizes and ends the year with fewer workers, its premium payouts may be less than predicted. If the discrepancy is small, the problem might be handled by offsetting the amount against allowable tax credits for the next year.

MAKING EMPLOYERS AWARE OF THE CREDIT

An important challenge involves developing a publicity campaign to acquaint employers with the tax credit. An outreach effort is a vital feature of a tax-credit program because past efforts at the state and local levels have been seriously limited by insufficient awareness of the subsidies' availability. A multimedia initiative could include a website with information on how to apply for the credit; newspaper, radio, and television public-service advertisements; and announcements through Chambers of Commerce and other business groups. The federal government needs to appropriate sufficient funds to ensure that the outreach effort is effective.

INTERACTING WITH OTHER PROGRAMS

The tax credit for employers will need to be coordinated with other programs to promote an integrated, comprehensive approach to broadening health coverage for uninsured workers and their families. As discussed above, even when employers offer and pay 50 percent of the cost of coverage, workers in firms newly offering coverage may still face significant financial barriers that discourage them from accepting such offers. Thus, it is important to couple efforts to get a good take-up rate among employers with a corresponding effort to obtain a good take-up rate among *employees*.

Many small firms that take the credit can be expected to contribute only the minimum amount, or 50 percent of the premium. A survey of low-wage employers who offered coverage found that among firms with 5 to 49 employees, 36 percent paid 50 percent or less of the premium. Among firms with between 50 and 99 employees, 41 percent paid 50 percent or less.⁹ It is likely that many firms taking the tax credit would pay the minimum 50 percent or just slightly more. Their workers might find that they could not afford to pick up the difference and would thus decline coverage.

As noted earlier, this line of reasoning supports federal subsidies for low-wage workers as well as their employers. States can also develop strategies for assisting low-wage workers who would have to contribute a substantial amount to employer-sponsored health coverage. For example, states could use both Medicaid and CHIP funds to assist workers with their contributions to premiums. Massachusetts, Mississippi, and Wisconsin have initiatives under way to do this. Florida and Oregon have proposals under review at the Health Care Financing Administration (HCFA).

Since the tax credits will be targeted to lower-wage firms, a substantial proportion of eligible workers will have children eligible for CHIP. A coordinated strategy for insuring the whole family could involve helping the parent afford the contribution to employer coverage while enrolling the children in CHIP. Alternatively, states have the

flexibility to enroll the whole family in CHIP if they can demonstrate that it is cost-effective to do so.

States could also reinforce the proposed federal program of tax credits for employers by offering tax credits or subsidies to low-wage workers to help them pay their share of the premium. Massachusetts recently began a statewide program that includes premium assistance both for small businesses with low-wage workers and for low-wage (low income) workers.¹⁰ (As noted earlier, a few states have tried this approach on a very limited basis, using very small credits.) States may want to consider using a tax-credit approach more in line with the one outlined in this report. While such credits would cost more than those tried earlier, states may be able to recapture some of the cost in the form of lower outlays under Medicaid and CHIP.

REGULATORY REQUIREMENTS

Since most of the firms that will be newly offering coverage if a tax-credit approach is implemented are small, it is important to consider how the market for small-group coverage operates. In the past, the small-group market did not work well. Insurers used costly resources to attract low-risk groups and avoided insuring high-risk groups. Higher-risk groups were denied coverage or charged prohibitively high rates. Individuals who changed jobs might be denied coverage by the insurer covering the new employer, or coverage for an existing illness might be excluded. Even low-risk groups paid more for coverage than large groups. Changes in both federal and state law corrected many of the worst abuses, so that now no small employer can be denied coverage. In addition, exclusions for preexisting conditions are limited to reasonable periods of time; employees who move to a new job are guaranteed coverage under the new employer's health plan; and premium variations between high-risk and low-risk groups are restricted.

Nevertheless, problems remain with the small-group market. The relevant federal law, the Health Insurance Portability and Accountability Act (HIPAA), is silent in terms of limiting the amount by which health plans can vary premium rates between high-risk and low-risk groups. States were left with responsibility for setting those limits. Although most states have imposed some limits, the permitted rate variation varies greatly from state to state. In some instances, the allowable rate variation between high-risk and low-risk groups can exceed a ratio of 10:1. This means that in some states, providing a substantial tax credit will not make coverage affordable for a small high-risk employer. Legislation limiting premium variation based on health status or past medical claims experience to reasonable levels might remedy this problem. The federal government has so far been reluctant to regulate in this area.

Another problem with the small-group market seems to offer no easy solution. A relatively high proportion of the premium goes to pay for administrative costs rather than medical expenses. Proponents of health purchasing alliances, coalitions, or cooperatives (HPCs) hoped that collective purchasing would produce savings in administrative costs and give small groups bargaining power to negotiate better rates generally. The expectation was that by centralizing some of the tasks such as marketing, premium collection and payment, and resolving claims disputes—tasks which would normally be done by individual companies and individual insurance agents—HPCs could achieve economies of scale.

Although HPCs have experienced some successes in other respects, they have not been able to reduce the cost of coverage appreciably for small employers. The evidence indicates that it will be difficult for them to reduce administrative costs unless they attain a substantially larger market share than they have yet been able to do. For this reason, a case could be made for requiring small employers who accept the tax credit to buy coverage through HPC-like entities. Such a requirement could help HPCs attain the critical-mass size that would let them achieve administrative savings. The lower premium that would result would induce more employers to accept the credit, which means that the federal subsidy would be more successful in getting uninsured people covered.

Alternatives to *requiring* participation in a HPC are (1) making sure that a purchasing alliance is *available*, or (2) permitting small employers to obtain coverage through state employee health programs. Under either scenario, small employers have the opportunity to benefit from key advantages of being part of a larger group entity. HPCs and most state employee programs allow individuals in a group to select different health plans. This increases the probability that employees and their families will be able to get coverage that permits them to keep their current doctors and to choose a plan that best meets their needs and preferences. Moreover, the economies of scale that HPCs achieve allow them to present comparative information about plan features and performance in a way that firms accepting the tax credit could not do on their own. Both employers and employees are likely to make better choices as a result.

The self-employed present special problems. Some self-employed people are low-wage “employers,” although they have only one employee (the owner). The small-group reform laws in a number of states define the self-employed as a “group of one.” HIPAA, however, includes only groups of two or more. For purposes of extending coverage to more uninsured people, a case could be made for making groups of one eligible for the tax credit. But this option poses many complications. Insurers argue that groups of one are

much like individually insured people, and that offering them coverage poses real dangers of adverse selection. Self-employed people who know that they need coverage will buy it, while healthier self-employed people will not. Insurers argue that some people start firms merely for the purpose of qualifying for (less expensive) group coverage. We propose to deal with this issue by making self-employed people eligible for the tax credit if their state's small-group reform laws apply to groups of one; otherwise they would be excluded. This seems to be a reasonable compromise, and it may mitigate some of the opposition that insurers would likely mount against the inclusion of the self-employed where state law does not define them as a group.

STRENGTHS AND WEAKNESSES

This employer tax-credit approach to subsidizing the expansion of health insurance coverage has significant strengths compared to other approaches. First, it is administratively simple. It requires no new bureaucracy nor significant new administrative apparatus; tax credits for business have been used many times previously. Monitoring and enforcement should be relatively easy. Employers who want to take advantage of the tax credit could do so without having to take on onerous burdens to prove eligibility or to conform with the rules.

Second, the tax-credit approach is politically more palatable than some other approaches. It does not require a federal budgetary authorization. The financing comes in the form of foregone revenues. Of course, the ultimate impact of foregone revenues is the same as if a comparable amount were spent on budget, but the political onus is smaller. In addition, the phase-out for higher-wage employers greatly reduces the cost in terms of foregone tax revenues. Finally, as outlined here, the tax credit for employers relies heavily on the market, in the sense that it delegates to employers the decision about how much and what kind of benefits to offer and gives them complete latitude in choosing health plans.

Third, this tax-credit plan is efficiently targeted. Since only low-wage firms (and their employees) are eligible, very little of the money would go to people who are not needy. Almost everyone who would end up with coverage—even those who were already covered—would be someone whose income is low enough that the subsidy is justified.

Fourth, by subsidizing employers, the approach encourages the expansion of *group* coverage, unlike a subsidy for individuals, which would likely expand *individual* insurance coverage. Group coverage is more efficient than individual coverage, with administrative

and marketing costs spread over a larger base. By pooling risk, group coverage stabilizes and evens out costs for people with varied risk profiles.

The most obvious disadvantage of the tax-credit approach is that it is incremental and would help only some of the uninsured. It would be targeted to workers, but not to all of them. Some employers who would qualify for the tax credit might never learn about it. Others may decline the credit, either because they distrust government or because they do not want to pay their share of the premium and make the implied promise to continue to do so. Even when employers offer coverage, some employees will decline it, either because the financial burden is still too great or for other reasons. Some will get coverage for themselves but not for their spouses or children.

An employer tax credit is less direct than an approach that subsidizes employees directly. Some employees who would buy coverage if the subsidy were provided directly to them rather than through their employers will not get coverage because the employer decides not to take advantage of the tax credit. In other words, the number of covered employees would probably be higher if the same credit were available directly to workers. On the other hand, workers who received a direct subsidy but whose employers did not provide coverage would be forced into the individual insurance market, where as mentioned above, a premium dollar buys less coverage and higher-risk people would have great difficulty getting affordable coverage. Correcting the deficiencies of the individual market is a very difficult task.

Finally, compared to a more comprehensive approach to achieving nearly universal coverage, employer tax credits would add yet another incremental layer of complexity on top of a very complex system for helping people finance health coverage. It would address only the financing problem of our health care delivery system; it provides no impetus for improved quality or efficiency, and simply adds to demand without any focus on controlling costs. But it shares these deficiencies with almost all other incremental reforms.

NOTES

¹ Jon R. Gabel et al., *Employer Health Benefits, 1999, Annual Survey, Executive Summary*, The Henry J. Kaiser Family Foundation and Health Research Educational Trust, 1999.

² Jonathan Gruber, "Tax Subsidies for Health Insurance: What Do We Need to Know, What Do We Know, and How Could We Learn More?," prepared for the Council on the Economic Impact of Health System Change conference, "Using Tax Policy to Reduce the Number of Uninsured," December 17, 1999.

³ Data and information cited below is taken from a review of the experience with employer tax credits discussed in Sharon Silow-Carroll, "Employer Tax Credits to Expand Health Coverage: Lessons Learned," unpublished paper prepared for the Commonwealth Fund, Economic and Social Research Institute, January 2000.

⁴ Stephen H. Long and M. Susan Marquis, "Employer-Based Health Insurance: Recent Trends, Buying Strategies, and Coverage Gaps," paper delivered at the conference "The Employer-Based Health Insurance System: Repair It or Replace It?," sponsored by Robert Wood Johnson Foundation, November 22–23, 1999, Washington, D.C.

⁵ Mark Pauly and Bradley Herring, "Cutting Taxes for Insuring: Options and Effects of Tax Credits for Health Insurance," prepared for the Council on the Economic Impact of Health System Change conference, "Using Tax Policy to Reduce the Number of Uninsured," December 17, 1999. Others have found much higher loading costs. See Beth Fuchs and Mark Merlis, *Private Health Insurance Options for Reform*. U.S. Government Printing Office, Committee Print 101-35, 1990.

⁶ Health Care Outlook Survey, 1991

⁷ Pauly and Herring, 1999.

⁸ Mark Merlis, *Public Subsidies for Required Employee Contributions Toward Employer-Sponsored Insurance*, The Commonwealth Fund, December 2000.

⁹ Economic and Social Research Institute, unpublished data from a September and October 1998 national survey of 1,200 employers offering health insurance coverage.

¹⁰ Sharon Silow-Carroll, Emily K. Waldman, and Jack A. Meyer, "Enhancing Health Coverage for the Working Uninsured: Lessons from State and Local Programs," draft paper prepared for The Commonwealth Fund, October 2000.

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#419 Allowing Small Businesses and the Self-Employed to Buy Health Care Coverage Through Public Programs (December 2000). Sara Rosenbaum, Phyllis C. Borzi, and Vernon Smith. Public programs such as CHIP and Medicaid offer the possibility of economies of scale for group coverage for small employers as well as individuals. This paper, part of the series *Strategies to Expand Health Insurance for Working Americans*, proposes allowing the self-employed and those in small businesses to buy coverage through these public plans, and providing premium assistance to make it easier for them to do so.

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#416 Transitional Subsidies for Health Insurance Coverage (December 2000). Jonathan Gruber, Massachusetts Institute of Technology and The National Bureau of Economic Research, Inc. The unemployed and those switching jobs often lose coverage due to an inability to pay premiums. This paper, part of the series *Strategies to Expand Health Insurance for Working Americans*, suggests ways that the existing COBRA program could be enhanced to help avoid these uninsured spells.

#414 Increasing Health Insurance Coverage Through an Extended Federal Employees Health Benefits Program (December 2000). Beth C. Fuchs, Health Policy Alternatives, Inc. The FEHBP has often been proposed as a possible base to build on for group coverage. This paper, part of the series *Strategies to Expand Health Insurance for Working Americans*, proposes an extension of FEHBP (E-FEHBP) that would operate in parallel with the existing program. The proposal would require anyone qualifying for a tax credit to obtain it through E-FEHBP and would also permit employees of small firms (<10 workers) to purchase health insurance through the program. The proposal would also provide public reinsurance for E-FEHBP, further lowering the premium costs faced by those eligible for the program.

#413 Private Purchasing Pools to Harness Individual Tax Credits for Consumers (December 2000). Richard E. Curtis, Edward Neuschler, and Rafe Forland, Institute for Health Policy Solutions. Combining small employers into groups offers the potential of improved benefits, plan choice, and/or reduced premium costs. This paper, part of the series *Strategies to Expand Health Insurance for Working Americans*, proposes the establishment of private purchasing pools that would be open to workers (and their families) without an offer of employer-sponsored insurance or in firms with up to 50 employees. All tax-credit recipients would be required to use their premium credits in these pools.

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programs that target employers and employees directly, but also on a sample of programs targeting a broader population.

#411 ERISA and State Health Care Access Initiatives: Opportunities and Obstacles (October 2000). Patricia A. Butler. This study examines the potential of states to expand health coverage incrementally should the federal government decide to reform the Employee Retirement Income Security Act (ERISA) of 1974, which regulates employee benefit programs such as job-based health plans and contains a broad preemption clause that supercedes state laws that relate to private-sector, employer-sponsored plans.

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#370 Working Without Benefits: The Health Insurance Crisis Confronting Hispanic Americans (March 2000). Kevin Quinn, Abt Associates, Inc. Using data from the March 1999 Current Population Survey and The Commonwealth Fund 1999 National Survey of Workers' Health Insurance, this report examines reasons why nine of the country's 11 million uninsured Hispanics are in working families, and the effect that lack has on the Hispanic community.

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