ALLOWING SMALL BUSINESSES AND THE SELF-EMPLOYED TO BUY HEALTH CARE COVERAGE THROUGH PUBLIC PROGRAMS

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EXECUTIVE SUMMARY

The uninsured population of the United States disproportionately comprises lower-income workers and their families, whose employers offer no health benefits. In most states, these workers are ineligible for Medicaid, even if their children are, and Medicaid is generally not available to lower-income workers without children. Thus, there is a need for a coverage initiative that fosters greater access to affordable benefits through employment, particularly in light of the strong support that employment-based coverage enjoys among the public.

Under this proposed program, states would organize a group health insurance market for small firms with low-wage workers. States would both stabilize the cost of coverage for participating employers and subsidize premiums for low-income workers. This program would be an extension of the State Children's Health Insurance Program (SCHIP) and states could volunteer to participate. The laws governing SCHIP are sufficiently flexible to permit this type of initiative.

The aggregate spending limits that are part of the SCHIP legislative authority would allow federal policy makers to control government outlays, and at the same time encourage more employers to participate. The proposal includes options for encouraging efficient administration and preventing insurance "crowd-out."

Under the proposal, which builds on a model that has been tested in Michigan, low-wage-employee subsidies could be calculated either in relation to the federal poverty level or hourly wage levels, whichever is administratively simpler.

States would identify eligible employers and market the program, certify participating insurers, determine which employees were eligible for the subsidy, and pay insurers.

States would be able to select participating health plans and structure member cost-sharing as they currently do under SCHIP. The federal government would contribute to the new program on the same basis that it currently contributes to SCHIP.

Employers would enroll eligible workers in the program, pay their share of their employees' premiums to the state, and report changes in employment status to the state.

Employees would apply for the subsidy and pay their share of the premium, perhaps through payroll deductions.

This program would be politically feasible because it would permit states to tailor their own plans to local conditions. It is also consistent with current thinking about public/private partnerships, the importance of preserving employer sponsored insurance, and the need to provide employers with incentives to provide benefits, but not compel them to do so.

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INTRODUCTION

This paper describes a proposal to expand the State Children's Health Insurance Program (SCHIP) to permit states to help small employers, including self-employed individuals, purchase health insurance. States would aid employers in two ways. First, they would organize a small-group health insurance market. This market would be financially stabilized through a negotiated purchasing process that includes a "buy-down" feature to assure reasonable cost increases both during the initial period of coverage, and subsequently. Second, states would subsidize the cost of coverage for low-wage employees at qualified firms in order to make enrollment affordable. Insurers wishing to participate in this program would have to meet similar standards that apply to SCHIP insurers, and would also have to comply with state insurance-related regulations.

This model differs from proposals to provide either direct financial assistance to low-income workers or direct tax subsidies to small employers. Benefits would flow to workers through an employment-based mechanism, rather than through programs into which individuals enroll directly, regardless of employment status. This model offers states the opportunity to more directly shape the small-group market, using subsidization both as a basis of authority and as a means of stabilizing the cost of insurance to firms and workers who otherwise would be priced out of the market.[1]

Opinion polls on health coverage, such as those conducted by the Employee Benefits Research Institute (EBRI) and The Commonwealth Fund, suggest that Americans see a strong connection between work and health benefits.[2] Despite the limitations of the employment-based system, both for nonworkers as well as an increasingly mobile workforce, individuals appear to believe that health benefits should be part of employee compensation. This proposal builds on the tradition of linking access to affordable benefits to employment, in a way that would appear to be compatible with people's expectations.

This proposal would merge pediatric and adult coverage into a unified workplace product whenever possible. Medicaid permits states to subsidize the enrollment of workers into employer plans under some circumstances, as does SCHIP in the case of children. However, both programs mainly provide direct access to coverage through a state-administered system that is separate from the workplace. Children are increasingly enrolled in freestanding state insurance plans under Medicaid and SCHIP. This could eventually

remove them from employer-based insurance pools, as employers alter their plan design in response to the availability of direct coverage for children. This could eventually stabilize pediatric coverage, especially for children whose parents work part time and change jobs frequently. However, covering children and adults separately could also increase costs for employer-based insurance pools, because the insurance risks and expenses are spread over fewer individuals. Administrators of state SCHIP programs have provided anecdotal evidence that working parents would prefer to obtain coverage for their children through workplace plans rather than through a separate program.[3]

Finally, this proposed model is consistent with current welfare-reform principles and operations. The Personal Responsibility and Work Opportunity Act of 1996 emphasizes work as the principal means of securing family economic support. As low-income families who otherwise would have received welfare increasingly move into the workplace, Medicaid enrollment seems to be declining, partly because families are breaking ties to welfare offices and welfare-related benefits.[4] A medical assistance program for lower-income workers that remains tied to welfare principles and procedures may not be viable in the long term. Although Medicaid and SCHIP coverage of low-income children might offset this coverage decline among children, no comparable mandatory program exists for working adults, although states do have the option to extend Medicaid to working adults with children. Greater access to workplace-based coverage may be crucial if low-income persons moving from welfare to work are to keep health insurance.

Our proposed model is obviously limited by the fact that it would promote workplace benefits and thus offers no coverage to persons who either do not work or whose employers choose not to participate. We assume that this proposal would be part of a broader strategy aimed at covering Americans without access to our proposed program.

The remaining sections of this paper describe the design of the proposal. The table below summarizes its key elements.

Key Features of Subsidized Employer-Based Health Plan Proposal

Issues	Details
Basic program design	A grant in aid program that would amend SCHIP to permit states to assist qualified employers who establish and support employer-sponsored health plans.
Qualified employers	"Employer": any entity that is an "employer" under ERISA; includes self-employed persons.
	"Qualified" employers: employers with firms of up to 25 employees (as set by state) that agree to contribute to the cost of employee coverage at or above a level set by the state (level set using 1 of 3 applicable benchmarks: state employee plan, small employers, or all employers)

Issues	Details
Qualified employees	All full- and part-time employees and their dependents. (State may use Internal Revenue Code definition of part-time)
Structure of subsidy	Subsidies paid by state to reduce and stabilize the cost to employers and employees for health insurance premiums. State options: If based on family income, subsidies would be for employees with family incomes up to the Earned Income Credit (EIC) upper limit, or an alternative limit set by the state. For employees with family income below 100% FPL, subsidy would be 100% of the employee share for the benchmark premium, plus 25% of the employer share. For employees with income from 100% to 150% of FPL, subsidy would be 75% of the employee share. For other employees who qualify, subsidy would be 50% of employee share. If based on individual wage rates, employee contribution subsidies would be: For employees earning up to $6 per hour, 100% of employee share for the benchmark premium, plus 25% of employer share. Above $6 per hour, each subsidy phases down at the rate of one percentage point for each $0.10 in employee wage rate. Thus, the employee subsidy phases out at $16 per hour, and the employer subsidy phases out at $8.50 per hour. Subsidies would be based on employee family income level or wage rate at the time of initial enrollment and reenrollment in accordance with standards set by the state. A 12-month enrollment period would be used. Premium stabilization: In the second and third years, if the insurance product cost increases faster than the MCPI, subsidies would be adjusted to compensate for the difference.
Benefits and cost-sharing	Benefits: SCHIP benchmark system used, including SCHIP rules regarding coverage of preventive pediatric services. In addition, maternity service coverage would be required. No cost-sharing for well-baby and well-child care.
Conditions of participation	Coverage and cost-sharing rules; compliance with applicable state and federal requirements; agreement to have three-year coverage agreements.
Administration	States, employers, and employees assume administrative tasks relevant to enrollment and premium payment. State would decide whether state or employer is responsible for overall payment to participating insurers.
Crowd-out	Participating states would be required to use waiting periods of 3 to 12 months for employers that wish to participate, during which time they cannot have offered subsidized insurance.
Fraud and abuse	Applicable federal and state law

PROGRAM DESIGN

A. SCHIP as the Legislative Basis

This proposal would establish a grant-in-aid program within SCHIP that permits states to design and offer affordable insurance products for qualifying employers. Insurers that meet a relatively simple set of conditions would be deemed qualified to offer coverage. States that establish a subsidy program would receive federal matching funds to pay for a percentage of their costs. We have selected SCHIP as the legislative basis because it is fundamentally different from Medicaid. Medicaid's statutory roots lie in welfare

entitlement law and theory, but SCHIP is a non-entitlement program, designed to subsidize the purchase of private health insurance.[5] By the end of 1999, virtually all states had an approved state plan for SCHIP, suggesting that there has been considerable enthusiasm for the program. Both the Clinton Administration and Vice President Gore have proposed to expand SCHIP benefits to reach parents of SCHIP children, so this proposal is consistent with the goal of family coverage.

Medicaid would be a less-feasible legislative basis for this type of proposal. Certainly Medicaid is an important source of coverage for lower-income working adults. States can use Medicaid to buy managed care-style insurance for most enrollees, and most currently do so.[6] Furthermore, states have an option to subsidize the purchase of employer-sponsored insurance when it is cost-effective and may expand their programs to cover all parents of eligible children.[7]

However, few states make use of this Medicaid coverage option for working-poor families. Furthermore, Medicaid includes a number of features that distinguish it from private insurance, such as a federal entitlement structure, a broad benefit package, and strict limits on cost-sharing. These requirements apply even for beneficiaries who receive at least a portion of their coverage through insurance (Medicaid-purchased or otherwise). These comprehensive minimum standards may make the program less attractive as a means to subsidize private insurance products, since enrollees would also remain legally entitled to full Medicaid coverage. Rather than diluting the Medicaid program for lower-income workers, we believe it is more sensible to build on a program with a less comprehensive structure to begin with. Moreover, the needs of lower-income workers and small employers for coverage assistance may fluctuate with economic conditions, and states may wish to have a program that is more flexible than Medicaid.[8]

Finally, because Congressional appropriations for SCHIP are subject to annual aggregate upper limits, using SCHIP as the vehicle for this program allows long-term federal controls over spending.

B. Qualified Employers

1. Defining the term "employer"

Our proposal is designed to encourage employers that otherwise would not be able to do so to offer and subsidize health benefits; it is also designed to help lower-wage employees take advantage of available benefits. When insurance benefits are available, lower-wage employees appear to enroll at high rates, even when out-of-pocket health

insurance spending may pose serious financial difficulties. The more common problem facing lower-wage workers is their employers' failure to offer any group health plan.[9]

This proposal targets employers least likely to offer coverage, and provides a range of incentives. As defined by ERISA, the term "employer" would include "any person acting directly as an employer, or indirectly in the interest of an employer, in relation to an employee benefit plan."[10] This definition includes self-employed individuals.

2. Qualification requirements

Employers qualified to participate in this program would have to fulfill two criteria related to both the size of the employer and to employer's contributions to employee health benefits.

Size: This program would be targeted to smaller employers who have limited access to group coverage and who, even if such coverage is available, might find it unaffordable. EBRI data on the insurance status of workers by employer size suggest that workers without health insurance are concentrated in firms of 25 employees or fewer. In 1997, nearly 35 percent of workers in firms with fewer than 10 employees were uninsured; about half of all uninsured workers were either self-employed or working in firms with fewer than 25 employees.[11]

Our proposal would permit states to design their programs to reach firms of 25 employees or fewer. For example, a state might assist firms of 10 employees or fewer in the first five years of the program, extending coverage to larger firms later on. However, a state might want to commence the program at the maximum size, since the cost of the product may decline if the market is open to potentially eligible firms.

Contribution requirements: The second question is whether employers should be required to contribute to the cost of coverage for workers and their dependents. Available EBRI data do not report on the proportion of small employers that offer individual and family subsidies to their employees (the data are available only for firms of 100 employees or fewer). However, even small employers with relatively affluent payrolls can face insurance access problems. Thus, the qualifying issue is not merely size but whether the program should be open only to employers that subsidize enrollment and if so, what level of subsidy should be required.

Since our proposal aims to preserve the traditional system of voluntary, employer-subsidized health benefits, the program should be targeted to employers that genuinely

would like to offer such benefits. We also recommend that employers be required to contribute to the cost of coverage for both workers and their dependents as a condition of participation, since dependent contribution is still the norm.

The next question is where to set this contribution requirement. One option would be to require employers to contribute the same percentage as the state does for its employees and their families. Another option would be to allow states to require employers to contribute the average amount contributed by small employers in the state that already offer benefits. A third option would be to use a standard based on all employers in the state, rather than all small employers. A fourth would be to give a state the option to use any of these contribution "benchmarks."

The state employee option has obvious attractions, since it would create parity between what states do for their employees and what they ask small employers to offer. However, it is not clear whether the same factors influence the subsidy levels offered by public and private sector employees, and thus, whether the state's level would be too high. The available data are also ambiguous in the case of benchmark employer practices. Bureau of Labor Statistics data indicate that in 1996, 80 percent of employers with fewer than 100 employees required employees to contribute a flat monthly amount, rather than a percentage of the premium. About 40 percent pegged the rate at $20–$50 per month for individual coverage. For family coverage, contribution levels were far greater, with the majority of employers requiring contributions of more than $100 per month and 11 percent requiring $300 or more per month.[12] The fact that the employer's contribution is expressed as a flat dollar amount makes it difficult to extrapolate to the percentage of premium that employers might be expected to contribute.

Given the limitations of these data, we recommend that states be given the option to set employer contribution requirements for workers and dependents at one of three possible levels: the state employee plan, a small-employer benchmark determined by state data, or a multi-employer benchmark, also determined by state data.

C. Qualified Employees

As noted, the term "qualified employees" would include all full- and part-time employees and their dependents, as the term is used in the Internal Revenue Code.

D. The Structure of the Subsidy

This model is designed to subsidize both employer and employee costs. In the case of the employer, the subsidy would take two forms. First, the state would stabilize the cost of the insurance product. Second, the state would subsidize costs for low-income workers.

1. Product subsidies for employers through premium stabilization

Regardless of whether the state designs and administers its own product or buys products from private insurers, we believe that to attract smaller employers that do not already offer coverage, the product would need to be subsidized, and premiums stabilized so that costs will be more predictable. This means that state programs would need to absorb annual insurance cost increases that exceed a certain annual percentage. States that elect to purchase and offer private insurance products might be able to negotiate with insurers to assume a portion of this risk. States that devise and administer their own products would assume the risk alone. In either case, annual adjustments to the employee and employer subsidies would stabilize premiums.

Even if the state managed to negotiate sharing risks with insurers, it would still bear some of the cost. In order to involve insurers in what might seem to be a high-risk market, a state presumably would have to assume some risk. Examples of the types of risks that could arise are a rapid and significant shift in the characteristics of the participant pool, or utilization rate or benefit cost increases that are significantly higher than projected levels. The current growth spiral, fueled in part by the cost of prescribed drugs, offers an example of unanticipated cost increases with numerous cases of insurance product price increases of 30 percent or more.

The cost of premium stabilization would have to be estimated. We recommend that insurers wishing to participate enter into three-year contracts that specify annual maximum price increases. This would permit states to assign a defined value to stabilization (i.e., the difference between the MCPI and the upper limit in the contract).

2. Individual subsidies for workers

The program would subsidize the share of the premium paid by lower-wage workers. States could choose a subsidy structure based either on family income (expressed as a percentage of the Federal Poverty Level [FPL]) or based on the hourly wage rate.

For a state that used the family income criterion, we recommend the following subsidy structure:

- The state would completely subsidize the employee share of the benchmark premium for workers with family incomes at or below the federal poverty level. In addition, the state would pay 25 percent of the employer's share. This would reduce the employer's contribution for the lowest-wage earners, whose wages and other benefits are so low that full employer contributions are less realistic. Thus, if the normal employer share in a particular state is 50 percent, for poverty level workers the contribution would drop to 37.5 percent.

- For workers with family incomes from 100 percent to 150 percent of the federal poverty level, the state would pay up to 75 percent of the employee share of the benchmark premium (as defined below);

- For workers with incomes from 150 percent of the federal poverty level to the upper income level allowed under the state program, the state would pay up to 50 percent of the employee's share of the benchmark premium. States could set the upper income limit at the level at which the Earned Income Credit (EIC) program phases out, or they could set an alternative upper limit;[13]

Workers' family incomes would be determined according to criteria set by the state, as is currently the case with SCHIP. Family income would be determined at the time of initial enrollment and subsequent reenrollment. Enrollment periods of 12 months would be required, with no interim redetermination of family income.

For a state that chose to determine eligibility based on hourly wage rates, we recommend the following subsidy structure:

- The state would completely subsidize the employee share of the benchmark premium for workers with hourly wages of $6.00 or less. In addition, the state would pay 25 percent of the employer's share.

- For workers with hourly wages from $6.00 to $16.00, the state would subsidize the employee share of the premium on a sliding scale. The subsidy would decrease by one percentage point for each $0.10 increase in the wage rate above $6.00. Thus the subsidy would phase down to zero at $16.00.

The poverty-level criterion is sensitive both to income and to the number of persons in the family. It is also the method by which state SCHIP programs determine eligibility. However, the wage-rate criterion may be simpler for employers unaccustomed

to poverty calculations, and no staff are needed to determine eligibility. In addition, the subsidy can be set to phase down more gradually as an individual's hourly wage increases.

E. Benefits and Cost-Sharing

Benefits: We recommend that this program adopt the same policy approach to benefits and cost-sharing that separate SCHIP programs use. Participating states could select one of three benchmark plans, such as the most popular commercial HMO in the state, the state employee benefit plan, or the Federal Employee Health Benefit Program. Alternatively, a state could design a benchmark equivalent plan, as permitted under current law. Plans offered under this program would thus continue current SCHIP standards regarding coverage of well-baby and well-child care. They would also adhere to employment-based ERISA plan standards regarding coverage of newborns and mothers' services, mental health parity, reconstructive surgery following breast cancer, etc. In addition, we recommend that all products would be required to offer maternity coverage.[14] Rules regarding COBRA continuation coverage would also apply.

Cost-sharing (deductibles, copayments, and coinsurance): Current SCHIP cost-sharing standards would apply. This means that cost-sharing for well-baby and well-child care would be prohibited, and copayments for pediatric care would be nominal, according to federal SCHIP guidelines.[15] The new program would set the same limit on cost-sharing for families as SCHIP does. Thus, for participating families above 150 percent of the FPL (or a similar amount expressed as a wage rate), total out-of-pocket costs (i.e., premiums, deductibles, and coinsurance) for covered services could not exceed 5 percent of annual family income. For families with incomes up to and including 150 percent of the FPL, total out-of-pocket costs for covered services could not exceed 2 percent of family income.

Even in states that elect to offer premium subsidy on an hourly wage, rather than a poverty level basis, we recommend that cost-sharing rules remain tied to family incomes. Families would be eligible for state rebates upon submission of receipts for cost-sharing that exceeds threshold levels. Such a subsidy would be similar to the flexible benefit tax subsidy under the Internal Revenue Code that is commonly used by higher income workers for out-of-pocket expenditures.

F. Conditions of Participation for Insurers

Participating insurers would be required to provide the same consumer safeguards that apply to existing SCHIP products in accordance with proposed Health Care Financing Administration (HCFA) regulations.[16] These standards include the use of a "prudent

layperson" standard for emergency care, provision of an internal grievance and complaint procedure, and disclosure of all benefits and coverage limitations and cost-sharing requirements. In addition, participating states would be required to provide a process for external impartial review of plan grievance decisions.

States that elect to design and administer their own plans would be required to meet the same requirements.

G. State Administration and Employer and Employee Responsibilities

Payment for the insurance products comes from three sources: the employer, the employee, and the state. We assume the state agency would assume overall responsibility for payment to insurers in accordance with the premium contribution requirements outlined above.[17] Rather than pay insurers directly, employers would select plans and then remit amounts owed to the state program, which in turn would calculate remaining amounts owed and pay the companies.

Participating states would assume the following tasks:

- Identifying eligible employers and marketing the program;
- Certifying participating insurers and making this information available to participating employers;
- Determining the eligibility of employees for the subsidy, as well as the amount of the subsidy for which they are eligible;
- Paying insurers on behalf of participating employers;
- Providing employers with educational materials and application forms needed to educate workers about the availability of the subsidy program.

Participating employers would be expected to carry out the following tasks:

- Distributing materials about the subsidy program and forwarding workers' subsidy applications to the state;
- Enrolling workers who desire to participate in either the benchmark insurance plan or whatever other plan the employer offers and the employee selects;

- Paying the state its share of the premium for each participating employee, as well as the employees' payments;

- Reporting changes in employment status to the state program.

Participating employees would be expected to carry out the following tasks:

- Applying for the subsidy where potentially eligible;

- Paying the amount owed to the employer (where possible by payroll deduction);

- Following any applicable enrollment procedures used by the employer or the state.

H. Safeguards Against Fraud and Abuse

We assume that the products made available through this program will be governed by state insurance laws, and by applicable standards under SCHIP. To the extent that federal ERISA law or applicable state laws address issues related to fraud and abuse, the same standards presumably would apply here.

I. "Crowd-Out" Concerns

A proposal of this nature obviously raises "crowd-out" concerns, because the products that would be made available may be less expensive and offer better coverage than those available to small employers in the open market. One way to address this issue would be to prohibit enrollment by employers who, within some retrospective period (e.g., six months) had offered subsidized employee health benefits. However, we assume that some crowd-out would occur, but that ultimately there would be a net expansion of coverage.

To address crowd-out, HCFA allows states to set a retrospective window under SCHIP of six months. A pilot program conducted by Michigan in the early 1980s, which was similar to this program in certain respects, used a 12-month waiting period. We recommend that states have the flexibility to use waiting periods of no fewer than 3 months and no longer than 12 months, since there are limited data on the impact of waiting period length on crowd-out, and since excessively long waiting periods will deny many workers access to insurance.

J. Treatment of Medicaid-Eligible Employees and SCHIP-Eligible Children

Many of the children eligible for benefits under this program would also be eligible for Medicaid or SCHIP. Children and adults who are entitled to Medicaid and who enroll in

a health benefit plan offered through this program would be considered to have third-party liability coverage. This would not affect their entitlement to Medicaid and presumably would save the state money by offsetting third-party liability. Children would be disqualified from SCHIP coverage if they acquired coverage through this program, since SCHIP is restricted to uninsured children.

K. Federal Financial Participation for Medical and Administrative Costs

We assume that the federal government would contribute to this program at current SCHIP rates for medical and administrative costs, with an aggregate per-state limit calculated according to anticipated take-up rates among eligible persons.

L. Calculating the Program "Take-Up" Rate: Past Experiences

The success of costs of the program will depend upon how many qualifying employers who do not currently offer health coverage choose to do so when their costs are subsidized. The following example provides some insight into take-up rates among eligible employers. As noted, during the 1980s Michigan established a pilot program, known as the "One-Third Share Plan," for businesses with 20 or fewer employees. The subsidy was equal to one-third of the actual cost of health insurance premiums for qualifying employees. Qualifying employees were those with earnings below 200 percent of the federal poverty level. [18] The pilot ran in one urban and one rural area in Michigan from 1988 to 1990; 23.5 percent (229 of 976) of businesses determined eligible for the subsidy decided to participate. The One-Third Share Plan was less generous to employers and employees than the program proposed here, but it provides some indication of how many employers might sign up.

Building on the pilot experience, in 1994 Wayne County (Detroit) began a one-third share plan named Health Choice. By spring 2000, after six years, a total of 18,000 persons in 1,800 businesses had health coverage through the county program. County officials estimate that 8,800 businesses qualify for the program, indicating that one in five has chosen to participate. This program is open to businesses of up to 99 employees that have not offered health coverage for at least 12 months and in which at least half of the employees earn $10.00 or less per hour. In 2000, the employee premium is $126 and the subsidy is $42 per month for comprehensive coverage through local managed care organizations.

M. The Political Landscape

We believe that this model is consistent with current thinking about public/private partnerships, the importance of preserving employer-based benefits, the need for states to

oversee and regulate insurance, and the need to provide employers with incentives to provide insurance, but not to compel them to do so. The plan allows each state government to tailor a unique program, consistent with existing variation in premiums, patterns of insurance coverage, and traditions of public program administration. This proposal would offer more generous subsidies than Michigan's One-Third Share Plan did in the 1980s. Whether the current employment market is sufficiently tight to make more generous subsidies necessary is a question that we cannot answer. The logical approach would be to calculate the cost of the most generous version of this program and then scale back if necessary.

We assume that the insurance industry would support the plan, since it creates a market, provides for relatively generous subsidies, and designs benefit packages similar to other market products. Most importantly perhaps, our proposal provides for states to provide "stop loss" systems to absorb cost increases that exceed the MCPI. This aspect of the proposal would presumably be attractive to insurers who otherwise would view the small employer market as too volatile and risky. State liability for excess risk might lead some insurers to try to increase prices unnecessarily, but states should have sufficient bargaining leverage, with Medicaid and public employee benefit programs, to negotiate aggressively for upper limits on annual cost increases.

N. Measuring Success

We assume that the major measure of success for this program would be the proportion of eligible employers who elect to participate, as well as the duration of their participation in the long term.

NOTES

[1] While the benefits secured by employers under this proposal would become part of their ERISA employee benefit plans, the requirements related to the structure and content of the insurance they secure under would have only an indirect effect on their ERISA plans and thus should not be subject to preemption. *New York Conference of Blue Cross and Blue Shield Plans v Travelers Insurance Co.* 514 U.S. 645 (1995). However, state standards applicable to consumer safeguards and other features of the program might or might not survive an ERISA preemption challenge. *Corporate Health Insurance Inc. v Texas Department of Insurance* 12 F. Supp. 2d 597 ([S.C. Tex., 1998] [state law external review process to review health plan coverage disputes preempted by ERISA]). Pending Congressional legislation to protect consumers enrolled in ERISA plans potentially would remedy this problem. See generally, Rand Rosenblatt, Sylvia Law and Sara Rosenbaum, *Law and the American Health Care System* (Foundation Press, New York, NY, 1997; 2000–2001 Supplement).

[2] Employee Benefit Research Institute, Employee Benefit Data Book (Washington, D.C., 1999); The Commonwealth Fund, *Listening to Workers: Challenges to Employer-Sponsored Coverage in the 21st Century* (New York, NY, January 2000).

[3] Discussions by Professor Rosenbaum with SCHIP directors from California, Colorado, and Connecticut as part of a project on SCHIP cost-sharing undertaken for United States Department of Health and Human Services in 1999.

[4] Leighton Ku and Brian Bruen, "The Continuing Decline of Medicaid Coverage" (Urban Institute, Washington D.C., Series A, No. A-37. December, 1999); Sara Rosenbaum and Kathleen Maloy, "The Law of Unintended Consequences," *Ohio State Law Journal* (Spring, 2000).

[5] The Blue Cross and Blue Shield Caring Program of Western Pennsylvania, the New York Child Health Plus Program, and the Florida Healthy Families Program, all served as models for SCHIP and were grandfathered into the original SCHIP statute. All three programs function as insurance subsidy systems.

[6] As of 1999, more than 40 states had negotiated agreements with comprehensive-service managed care organizations who contracted to serve certain portions of the Medicaid population. Sara Rosenbaum et. al, *Negotiating the New Health System: A Nationwide Study of Medicaid Managed Care Contracts* (3rd ed., 1999), The George Washington University Medical Center, School of Public Health and Health Services.

[7] §1906 of the Social Security Act.

[8] The welfare reform amendments of 1996 permit states to extend Medicaid to working parents with children. See generally, "HCFA, Supporting Families in Transition: A Guide to Expanding Coverage in a Post-Welfare Reform World" (www.hcfa.gov\Medicaid, Letter to State Medicaid Directors, dated March 15, 1999). As of the end of 1999, only a small number of states had taken advantage of this provision, either as a state option or as part of a broader Medicaid demonstration.

[9] Ellen O'Brien and Judy Feder, "Employment-Based Insurance Coverage and Its Decline: The Growing Plight of Low-Wage Workers" (Kaiser Commission on Medicaid and the Uninsured, Washington, D.C., May 1999).

[10] ERISA §3; 29 U.S.C. §1002(5).

[11] Fronstin, Paul, "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 1998 Current Population Survey," Employee Benefit Research Institute (EBRI) Issue Brief, December 1998, Table 4, p. 9, Chart 7, page 18. Other studies have documented the different insurance experience by size of firm. For example, a recent study in Florida found 1999 rates of uninsurance of 24.6% among firms with 1–9 employees, 14.9% among firms with 10–24 employees, 12.0% for firms with 25–49 employees, 8.3% for firms with 50–99 employees, and 4.8% for firms with 100 or more employees. See: "Florida Health Insurance Study: Statewide Summary 2000," Table 10, page 13. Florida Agency for Health Care Administration, Spring 2000.

[12] Bureau of Labor Statistics, op. cit., Tables 42–43.

[13] For 1999, the maximum qualifying income level for workers with children is $30,500 for EIC purposes.

[14] The Pregnancy Discrimination Act reaches only employers with 20 or more employees; in the absence of state law prohibiting discrimination on the basis of pregnancy, insurers would not be obligated to cover maternity benefits.

[15] HCFA Letter to State Medicaid Directors, February 13, 2000.

[16] 64 Fed. Reg. 60882 (Nov. 8, 1999).

[17] Under an alternative approach, the employer would assume responsibility for paying the insurer, would submit evidence of payment of premium to the state, and would receive a subsidy payment from the state. This was the approach used in the Michigan Health Care Access Project in the late 1980s, in which the subsidy was a flat one-third of the actual premium paid by the employer.

[18] "An Assessment of the Health Care Access Project (HCAP), 1988 and 1989," Health Management Associates, prepared for the Michigan League for Human Services, September 1990.

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#415 *Challenges and Options for Increasing the Number of Americans with Health Insurance* (January 2001). Sherry A. Glied, Joseph A. Mailman School of Public Health, Columbia University. This overview paper summarizes the 10 option papers written as part of the series Strategies to Expand Health Insurance for Working Americans.

#442 *Incremental Coverage Expansion Options: Detailed Table Summaries to Accompany Option Papers Commissioned by The Commonwealth Fund Task Force on the Future of Health Insurance* (January 2001). Sherry A. Glied and Danielle H. Ferry, Joseph L. Mailman School of Public Health, Columbia University. This paper, a companion to publication #415, presents a detailed side-by-side look at all the option papers in the series Strategies to Expand Health Insurance for Working Americans.

#423 *A Health Insurance Tax Credit for Uninsured Workers* (December 2000). Larry Zelenak, University of North Carolina at Chapel Hill School of Law. A key issue for uninsured adult workers is the cost of insurance. This paper, part of the series Strategies to Expand Health Insurance for Working Americans, proposes using a tax credit to help workers afford the cost of coverage. It assumes age-/sex-adjusted credits averaging $2,000 per adult or $4,000 per family, with a full refundable "credit" for those with incomes at or below 200% percent of poverty. The paper analyzes administrative and other issues related to the use of such tax credits.

#422 *Buying into Public Coverage: Expanding Access by Permitting Families to Use Tax Credits to Buy into Medicaid or CHIP Programs (December 2000).* Alan Weil, The Urban Institute. Medicaid and CHIP offer administrative structures and plan arrangements with the capacity to enroll individuals and families. This paper, part of the series Strategies to Expand Health Insurance for Working Americans, proposes permitting, but not requiring, tax-credit recipients to use their credits to buy into Medicaid or CHIP.

#421 *Markets for Individual Health Insurance: Can We Make Them Work with Incentives to Purchase Insurance?* (December 2000). Katherine Swartz, Harvard School of Public Health. Efforts to improve the functioning of individual insurance markets require policy makers to trade off access for the highest-risk groups against keeping access for the lowest risk-groups. This paper, part of the series Strategies to Expand Health Insurance for Working Americans, discusses how individual insurance markets might best be designed in view of this trade-off.

#420 *A Workable Solution for the Pre-Medicare Population (December 2000).* Pamela Farley Short, Dennis G. Shea, and M. Paige Powell, Pennsylvania State University. Adults nearing but not yet eligible for Medicare are at high risk of being uninsured, especially if they are in poor health. This paper, part of the series Strategies to Expand Health Insurance for Working Americans, proposes new options to enable those 62 and older early buy-in to Medicare (or to subsidize other coverage) through premium assistance for those with low lifetime incomes and new health IRA or tax-deduction accounts for those with higher incomes.

#418 *A Federal Tax Credit to Encourage Employers to Offer Health Coverage* (December 2000). Jack A. Meyer and Elliot K. Wicks, Economic and Social Research Institute. Employers who do not currently offer health benefits to their employees cite costs as the primary concern. This paper, part of the series Strategies to Expand Health Insurance for Working Americans, examines the potential of offering tax credits (or other financial incentives) to employers of low-wage workers to induce them to offer coverage.

#417 *Public Subsidies for Required Employee Contributions Toward Employer-Sponsored Insurance* (December 2000). Mark Merlis, Institute for Health Policy Solutions. Some uninsured workers have access to employer group coverage but find the cost of their premium shares unaffordable. This paper, part of the series Strategies to Expand Health Insurance for Working Americans, examines the potential for using a tax credit or other incentive to help employees pay their share of premium costs in employer-sponsored plans. The paper analyzes how such premium assistance might work as an accompaniment to a tax credit for those without access to employer plans.

#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.

#425 *Barriers to Health Coverage for Hispanic Workers: Focus Group Findings* (December 2000). Michael Perry, Susan Kannel, and Enrique Castillo. This report, based on eight focus groups with 81 Hispanic workers of low to moderate income, finds that lack of opportunity and affordability are the chief obstacles to enrollment in employer-based health plans, the dominant source of health insurance for those under age 65.

#424 *State and Local Initiatives to Enhance Health Coverage for the Working Uninsured* (November 2000). Sharon Silow-Carroll, Stephanie E. Anthony, and Jack A. Meyer, Economic and Social Research Institute. This report describes the various ways states and local communities are making coverage more affordable and accessible to the working uninsured, with a primary focus on 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.

#392 *Disparities in Health Insurance and Access to Care for Residents Across U.S. Cities* (August 2000). E. Richard Brown, Roberta Wyn, and Stephanie Teleki. A new study of health insurance coverage in 85 U.S. metropolitan areas reveals that uninsured rates vary widely, from a low of 7 percent in Akron, Ohio, and Harrisburg, Pennsylvania, to a high of 37 percent in El Paso, Texas. High proportions of immigrants and low rates of employer-based health coverage correlate strongly with high uninsured rates in urban populations.

#405 *Counting on Medicare: Perspectives and Concerns of Americans Ages 50 to 70* (July 2000). Cathy Schoen, Elisabeth Simantov, Lisa Duchon, and Karen Davis. This summary report, based on *The Commonwealth Fund 1999 Health Care Survey of Adults Ages 50 to 70,* reveals that those nearing the age of Medicare eligibility and those who recently enrolled in the program place high value on Medicare. At the same time, many people in this age group are struggling to pay for prescription drugs, which Medicare doesn't cover.

#391 *On Their Own: Young Adults Living Without Health Insurance* (May 2000). Kevin Quinn, Cathy Schoen, and Louisa Buatti. Based on The Commonwealth Fund 1999 National Survey of Workers' Health Insurance and Task Force analysis of the March 1999 Current Population Survey, this report shows that young adults ages 19–29 are twice as likely to be uninsured as children or older adults.

#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.

#364 *Risks for Midlife Americans: Getting Sick, Becoming Disabled, or Losing a Job and Health Coverage* (January 2000). John Budetti, Cathy Schoen, Elisabeth Simantov, and Janet Shikles. This short report derived from The Commonwealth Fund 1999 National Survey of Workers' Health Insurance highlights the vulnerability of millions of midlife Americans to losing their job-based coverage in the face of heightened risk for chronic disease, disability, or loss of employment.

#363 *A Vote of Confidence: Attitudes Toward Employer-Sponsored Health Insurance* (January 2000). Cathy Schoen, Erin Strumpf, and Karen Davis. This issue brief based on findings from The Commonwealth Fund 1999 National Survey of Workers' Health Insurance reports that most Americans believe employers are the best source of health coverage and that they should continue to serve as the primary source in the future. Almost all of those surveyed also favored the government providing assistance to low-income workers and their families to help them pay for insurance.

#362 *Listening to Workers: Findings from The Commonwealth Fund 1999 National Survey of Workers' Health Insurance* (January 2000). Lisa Duchon, Cathy Schoen, Elisabeth Simantov, Karen Davis, and Christina An. This full-length analysis of the Fund's survey of more than 5,000 working-age Americans finds that half of all respondents would like employers to continue serving as the main source of coverage for the working population. However, sharp disparities exist in the availability

of employer-based coverage: one-third of middle- and low-income adults who work full time are uninsured.

#361 *Listening to Workers: Challenges for Employer-Sponsored Coverage in the 21st Century* (January 2000). Lisa Duchon, Cathy Schoen, Elisabeth Simantov, Karen Davis, and Christina An. Based on The Commonwealth Fund 1999 National Survey of Workers' Health Insurance, this short report shows that although most working Americans with employer-sponsored health insurance are satisfied with their plans, too many middle- and low-income workers cannot afford health coverage or are not offered it.

#262 *Working Families at Risk: Coverage, Access, Costs, and Worries—The Kaiser/Commonwealth 1997 National Survey of Health Insurance* (April 1998). This survey of more than 4,000 adults age 18 and older, conducted by Louis Harris and Associates, Inc., found that affordability was the most frequent reason given for not having health insurance, and that lack of insurance undermined access to health care and exposed families to financial burdens.