BUYING INTO PUBLIC COVERAGE: EXPANDING ACCESS BY PERMITTING FAMILIES TO USE TAX CREDITS TO BUY INTO MEDICAID OR CHIP PROGRAMS

Alan Weil
The Urban Institute

December 2000

Strategies to Expand Health Insurance for Working Americans
A Report Series from The Commonwealth Fund Task Force on the Future of Health Insurance

Support for this research was provided by The Commonwealth Fund. The views presented here are those of the author and should not be attributed to the Urban Institute or its trustees, or to The Commonwealth Fund or its directors, officers, or staff, or to members of the Task Force.

Copies of this report are available from The Commonwealth Fund by calling our toll-free publications line at 1-888-777-2744 and ordering publication number 422. The report is also available on the Fund's website at www.cmwf.org.

CONTENTS

EXECUTIVE SUMMARY

A new tax credit that could be used to purchase health insurance has emerged as a politically feasible mechanism to expand health insurance coverage in the US. Tax credits will certainly make coverage more affordable for low-income people, but a significant number will remain uninsured if there are no adequate, reasonably priced plans for them to buy. Many low-income people who would receive a health insurance tax credit work for employers that don't provide health insurance already. These individuals might use their tax credits to purchase health insurance in the non-group market, but such plans tend to be expensive, and are often less comprehensive than group plans. Allowing tax credit recipients to buy into the State Children's Health Insurance Program (CHIP) or Medicaid would provide them an alternative to the non-group market.

Some families may still wish to use the tax credit to buy insurance in the non-group market. Medicaid or CHIP should be particularly appealing to working families with children with incomes below 200 percent of the Federal Poverty Level (FPL). Most of the children in such families are already eligible for Medicaid or CHIP, but most of the adults are not eligible for any form of public insurance. The buy-in program would permit the adults to have the same source of coverage as their children, simplifying enrollment and care-seeking. In addition, many CHIP- or Medicaid-eligible children are not enrolled. Making their parents eligible for the same coverage might encourage more families to sign their children up. A further advantage of the buy-in program is that Medicaid families moving from welfare to work will be able to retain the same health insurance plan as their incomes rise.

Each state would have the option to design its own buy-in program. An implementation plan, including details of who would be eligible for the expanded Medicaid or CHIP programs, would be submitted to the U.S. Department of Health and Human Services (DHHS). Upon approval of the plan, states would be responsible for processing enrollment applications, obtaining the federal tax credit on behalf of enrolled families, and administering benefits. The Treasury Department would administer the tax credit and make payments to the states for every tax credit recipient enrolled in the state's buy-in program.

In 2000, the proposed tax credit would amount to $2,000 per individual and $4,000 per family with earnings below 200 percent of the FPL, and would phase out at higher incomes. States would determine the value of the credit at the time the family enrolls in the buy-in program. This avoids the need for year-end reconciliation, and eliminates large tax bills for families whose incomes rise during the year.

Some states may offer Medicaid and CHIP only to those families eligible for the full tax credit, and not require any premium contribution from these families. Other states may open up their buy-in programs to higher-income families receiving a partial tax credit, and require a premium contribution from them. Still other states may even make a contribution to the premiums of higher income families who wish to use their partial tax credit to enroll in the buy-in program.

Each state would define the cost-sharing and co-payment structure of the benefit package. CHIP is an obvious model, but the services covered would need to be designed for adults as well as children. Some states may choose to define a narrower benefit package if the full tax credit turns out to be worth less than the cost of enrolling a family in Medicaid or CHIP.

The measure of success of any program to expand health insurance coverage is the number of previously uninsured people who become insured under the program. The tax credit approach and the buy-in option are both subject to some degree of crowd-out, that is, some people who already have insurance will shift to the buy-in program, and this will not result in a net increase in insurance coverage. The provision allowing the tax credit only for people who buy coverage in the non-group market is designed to reduce the amount of crowd-out. Since the tax credit is available to low-income families, there is some risk that states would encourage their Medicaid population to disenroll from the program and use their tax credits to enroll in the private, non-group insurance market. In this way, the federal government would be responsible for their entire health insurance costs, reducing state Medicaid costs. This problem may arise with any tax credit proposal, not just the buy-in option. Some federal oversight to ensure this does not happen will be necessary.

If the non-group market is highly risk-rated, high-risk individuals will prefer the state buy-in option, and the program will be subject to adverse selection. Waiting periods or exclusions from the buy-in program if other sources of insurance are available might mitigate this problem, as would scaling back the benefit package, so that it would be less attractive to high-risk individuals. Of course, this may make it less attractive to other people too. A tax credit proposal that relies upon a well-functioning non-group market will draw attention to the strengths and weaknesses of that market. A buy-in option offers a safety valve in case the non-group market cannot meet the needs of the low-income population targeted for coverage through the new tax credit.

BUYING INTO PUBLIC COVERAGE: EXPANDING ACCESS BY PERMITTING FAMILIES TO USE TAX CREDITS TO BUY INTO MEDICAID OR CHIP PROGRAMS

PLAN OVERVIEW

This paper outlines a program that would permit families eligible for a health insurance tax credit to buy into a publicly administered insurance system, such as Medicaid or CHIP. Tax credits will achieve their goal of expanding health insurance coverage only if currently uninsured people have an effective mechanism for purchasing insurance with their new credit. Tax credits alone address only the issue of cost; a plan that provides tax credits but does nothing more will continue to leave many uninsured. Even affordable programs are under-used. For example, while high premium costs are the primary reason people give for not buying health insurance[1], many people who are eligible for free coverage under Medicaid or the new State Children's Health Insurance Program (CHIP) do not enroll. The program described here would provide families with an existing group that can accept their credit, manage the enrollment process, and assure a reasonable benefit package. Throughout this paper I refer to this as a "buy-in" option.

As will be discussed in more detail below, the buy-in option offers three primary benefits. First, it provides continuity of coverage for low-income families as their incomes change. Because eligibility for most public programs is tied to income, small increases in earnings may cause some families to become ineligible. The buy-in program assures that they may remain in the same insurance plan, even as their income rises and they become eligible for a tax credit. Second, it provides an alternative to the complexities of the non-group market. This plan assures that there is an affordable, already-existing option for those who want to use their credit to obtain new insurance coverage. Finally, by placing an intermediary between the family and the federal government, it allows for a design that avoids the risks inherent in a year-end reconciliation process. Families concerned about the possibility of making insurance premium payments during the year, only to find that their tax subsidy has fallen short at year-end, may prefer to participate in this program.

The infrastructure of Medicaid and CHIP can easily be expanded to provide an option for new entrants into the insurance market. Although many families may wish to use a new federal tax credit to purchase private insurance, extending an existing infrastructure of plan choice, consumer education, and premium collection to these families has many advantages. States already dedicate many resources to Medicaid programs that provide health insurance to low-income families. More recently, states have used the significant flexibility granted under CHIP to simplify eligibility and expand outreach.[2] Welfare reform formally broke the link between Medicaid and cash assistance, providing new impetus for states to treat their health insurance programs as support for

low-wage working families, not just welfare recipients. At the same time, Medicaid and CHIP programs are becoming increasingly privatized, with private firms providing consumer education and enrollment functions, and private HMOs organizing the delivery system.[3]

The buy-in option presented here would be an adjunct to a tax credit of $2,000 for individual and $4,000 for family coverage for people with incomes up to 200 percent of the federal poverty level (FPL). The credit would phase out at higher incomes. The credit would be available to anyone who purchases health insurance and who is not at the same time covered by employer-sponsored insurance, Medicare, Medicaid, or CHIP.[4] The buy-in option is, as its name implies, an option. While an eligible family may buy into public coverage, the family may instead use the tax credit to purchase private insurance in the open market.

States would have strong incentives to make the buy-in option available to their citizens, but they would not be required to do so. States would submit their own implementation plans to the federal government, process enrollment applications, and obtain the federal tax credit issued on behalf of enrolled families.

Interested families would apply for the federal tax credit through their participating state agency. The state would prospectively calculate the premium cost-share required by the family. States would be expected, but not required, to develop a zero-premium plan—that is, one that requires no out-of-pocket premium payment by a family or individual receiving the full federal tax credit. Other options that require the family to pay a premium beyond the value of the tax credit might be available. A state could also supplement the federal tax credit using its own revenues, in whatever manner it wished, to expand benefits, reduce cost-sharing, or expand the choices available to participating families.

Together, state and family choices would determine the number of tax credit recipients who participate in the buy-in option. If the private, non-group insurance market is strong, relatively few families may participate in the buy-in. But for those that do, this program would almost certainly convert otherwise uninsured families into insured ones. In states where the private, non-group insurance market is weak, this option may be essential for tax credits to achieve the goal of increasing health insurance coverage.

THE HISTORY OF RELATED EFFORTS

While this paper describes a new program, it builds upon state experience extending Medicaid programs to higher income families.

Experiences with Programs for Families

From the family's perspective, state buy-in programs would look similar to those already adopted by a handful of states through waivers granted under Section 1115 of the Social Security Act. For example, Minnesota and Tennessee each have programs that allow families with incomes above the normal Medicaid qualifying levels to purchase, on a sliding fee scale, into a program that also serves many families with lower incomes. The Washington Basic Health Plan, although not operated as an 1115 waiver, has a similar structure.[5]

While the financing structures that underlie each of these programs differ, they share a common feature. Every program has attracted some people who presumably could have purchased health insurance in the non-group market, but who found the state-administered program more desirable. While it is possible that some of these families would enter the private market if the state program did not exist, it is more likely that they would be uninsured. Therefore, state buy-in options to expand the availability of health insurance have demonstrated, albeit on a limited scale, that they can reach people who find the non-group market undesirable or unavailable.

Experiences with Similar Federal-State Models

From a federal-state perspective, this program would be quite different from Section 1115 waiver programs. Most Medicaid waiver programs, once budget neutrality is negotiated, continue to operate on a fee-for-service cost-sharing system between the federal government and the states. That is, states report their expenditures under the program, and the federal government pays its share at the Medicaid match rate. If the number of eligible families increases or declines, or the per-eligible cost changes, the federal payment to the state changes accordingly. While the CHIP match rate is higher than that for Medicaid, the mechanics of the program are similar.

In the program described here, the federal government's only obligation to the state is to remit the tax credit on behalf of the taxpayer. Management of program costs is entirely at the risk of the state. From the federal government's perspective, this design is much simpler than the current Medicaid program. From the state's perspective, the program operates as any other, with costs and appropriations calibrated to program need.

As discussed below, the state plays a new role in this model. The state would gather tax credit eligibility information from individuals and use that information to determine the funds it should receive from the federal government. This relationship might be complex, but it is essential to the proposal.

TARGET POPULATION

The buy-in option is likely to appeal to only a subset of the population eligible for tax credits. In order to identify those most likely to take advantage of this option, it is worth reviewing who would be eligible for the new tax credits. Tax credits go to low- and moderate-income families, but are not available to anyone with employer-sponsored coverage or who is enrolled in Medicaid or CHIP.

These rules create three categories of families. The first category includes families with children with incomes below 200 percent of the FPL. Most of the children in such families are eligible for Medicaid or CHIP, but most of the adults are not eligible for any form of public coverage.[6] The second category includes families with children with incomes above 200 percent of the FPL; in most of such families no one is eligible for public coverage. The third category consists of adults without children regardless of income, who, except in a very few states, are not eligible for any form of public coverage unless they are disabled. By definition, in order to be eligible for a tax credit, these families would have to have at least one currently uninsured person. The question is whether or not the new tax credit will lead to the uninsured members of these families obtaining health insurance.

Each of these groups is large. Data from the 1997 National Survey of America's Families shows that of the 21.1 million low-income (below 200% of the FPL) parents, 7.3 million are uninsured. Fifty-seven percent of the children of these uninsured parents are uninsured themselves, while 34 percent have Medicaid coverage.[7] Among higher-income parents, 2.5 million, or 6 percent, are uninsured. Finally, 17 million adults without children are uninsured, of which 9.6 million are low-income. Fully 38 percent of low-income adults without children are uninsured.[8]

The buy-in program has potential advantages for all three of these types of families, but the advantages are greatest for the first type. Children in families in this category are already eligible for public coverage (although, as the data above show, may of these children are not enrolled). If there is no buy-in option, the family has two choices for using its tax credit. First, the parents can use the tax credit to buy a non-group policy while the children remain enrolled in Medicaid. In this case, the parents and children

would be covered by different health plans, creating complexity and possible barriers to receiving timely, necessary services. The family could also pull the children out of Medicaid or CHIP and buy a family policy using the family tax credit. In so doing, the family enters the mainstream health insurance market, but almost certainly receives a narrower benefit package for its children. Also, in the fairly likely circumstance that the tax credit is worth less than the cost of a family policy in the non-group market, the family will face a premium. That premium (net of the credit) may be small, and will not pose a barrier for all families, but for others it may make this second option unrealistic or unattractive.

If this low-income family can use the parents' tax credit to buy into the state's Medicaid or CHIP program, the family retains the Medicaid or CHIP benefit package for the children and has a single insurance plan covering all family members. This prospect should appeal to many families. New health insurance will be provided for very low-income parents, and access to services for their children may improve, as the whole family will only need to navigate one delivery system. This might also improve enrollment rates for eligible Medicaid and CHIP children, since the entire family would be able to obtain insurance, not just the children.

The buy-in program may also appeal to some families in the latter two categories—those without children eligible for CHIP or Medicaid, or without children at all. For these families, the buy-in option provides an alternative to the non-group market. If the buy-in plan offers a good benefit package compared to that available in the private market, and a provider network perceived as high quality, some families may prefer this option to non-group coverage.

ADMINISTRATION

State

The state plays a role in administration only for those families that choose to participate in the buy-in program. That is, the core tax credit would be administered in its normal fashion for families that use it to purchase private coverage.

State participation is voluntary and depends upon HHS approval of a state plan. The state begins by extending its existing Medicaid or CHIP program to a new group of enrollees. This extension would involve the same activities these agencies currently perform—enrolling clients, educating them about their options, signing up managed care plans or providers, making capitation payments, or paying claims directly. In all of these areas there would be some marginal increase in volume, but no substantive change in the

work of the agency. Presumably this expansion will benefit from some economies of scale for program operations, as well as the possibility of enhanced purchasing and bargaining power for the state. Thus, from the perspective of administering the benefits, program administrative costs will likely be small.

The program would involve a new role for the states, which would now act as intermediaries between individuals and the federal government. A tax credit—even one that is refundable and payable over the course of the tax year—must be reconciled at year-end. That is, the precise value of the credit is only determined once the tax return is filed and the taxpayer's income and eligible expenses are known. As discussed by Zelenak (2000), this feature of a tax credit may discourage some families from participating, especially those who are uncertain about their earnings for the coming year and apprehensive about having to repay large sums of money to the government at the end of the year.

A critical component of the buy-in option is that the state must buffer the individual from the uncertainty inherent in year-end reconciliation. That is, the state must make a determination *at the time of application* of what the expected family credit will be through the balance of the year, and the federal government must accept that determination as final, thereby eliminating reconciliation. The plan submitted by the state to the federal government should include the methods the state would use to determine eligibility, with the expectation that there will be some federal audit of this activity. An alternative would be to have states turn over a portion of the application process to the federal government, to prevent any concerns that states might over-qualify individuals. Yet another option is for the state to bear the risk of its own errors. In this way, the state would reconcile with the federal government at year-end, based upon the difference between the value of the credits the state claimed at the beginning of the year and the sum of the credits actually owed to the families on whose behalf it claimed them[9].

All of these options involve some complexity. Longer periods of eligibility may help reduce administrative costs and attract families. But if the state bears the risk of losing federal funds when a family's income rises, it may wish to require more frequent redeterminations of eligibility. If the federal government bears the financial risk, it may also demand more frequent redeterminations. This tension between accuracy and simplicity is inherent in the design of this program, and it is critical that policy balances these priorities.

While the idea that states could claim a federal tax credit may seem odd, it is commonplace for states to administer federally financed benefits. The application process currently employed for most public benefits—cash welfare (Temporary Assistance for Needy Families, or TANF), Medicaid, food stamps etc.—requires states or counties to make prospective determinations of family eligibility for benefits based upon historical financial information. Eligibility is assured for a certain time, ranging from a month to as long as a year, regardless of changes in family circumstances. In each of these programs, federal funds are involved, and there is a reasonable chance that, if eligibility were not approved, the costs of serving these families would fall entirely to the state. For Medicaid and TANF, eligibility standards vary tremendously from state to state, even though federal benefits are at stake.

An alternative model is provided by the Supplemental Security Income (SSI) program. SSI is administered by the Social Security Administration, and eligibility is determined locally by federal officials under federal standards. One possible design for the buy-in program is to have the federal government determine income eligibility, while the state administers health benefits, as occurs with Medicaid benefits that are automatically given to those eligible for SSI.

For applicants, full state administration is far preferable. Still, the need to avoid a year-end reconciliation is so central to the success of the buy-in option that any allocation of responsibilities between the states and the federal government that achieves this goal must be considered.

If states administer the program, each would develop an application form that collects information about the applicant's expected income for the tax year. Based on this information, the state would calculate an estimated tax credit for each family. Each month the state would submit a claim to the federal government for payment, which would be the sum of the estimated tax credits for all families eligible for that month. This amount represents the full obligation of the federal government to the state, and it would be expected to cover health care costs as well as program administration.

Maximum income eligibility for the buy-in option would be entirely up to each state. For families with income higher than that at which the federal tax credit phases out to zero, there is no federal financial involvement, so this program would function just as any other state-only program would. For the purposes of this analysis, any families with income that high are ignored. States could set a lower income cap than that at which the federal tax credit phases out, although there is no particular reason why they would do so.

Families receiving the maximum federal credit, and whose credit covers the full cost of insurance, would in essence become part of the Medicaid or CHIP eligibility pool. Since the target group for this program is lower-income families eligible for the maximum tax credit, and given the structural advantages of setting up the state program so that families need not make additional premium payments, it is reasonable to expect that most program participants would fall into this category.

For families receiving only a partial credit, or where there is no zero-premium option, the state will need to collect the balance due from the family. Models for this sort of collection exist in Section 1115 waiver states and many CHIP programs. Requiring premium payments increases administrative costs and reduces program participation, but does differentiate the program from "welfare." There is sufficient variation in state approaches within current Medicaid and CHIP programs to suggest that there is no national consensus on the appropriate degree of premium cost-sharing. State choices under this new buy-in option will presumably continue to reflect this variety. At the end of each tax year the state would provide the federal government with a list of the Social Security numbers of people participating in the state program. Participants are barred from claiming the federal tax credit on their tax return. People who move from one state to another mid-year would need to apply for benefits in the new state, since, even though eligibility for the tax credit is uniform nationally, other aspects of the buy-in program may differ.

Federal

The Department of the Treasury would be responsible for most of the overall administration of the tax credit. As discussed above, the federal government would make payments to states on behalf of eligible families who choose to participate in the buy-in program. Oversight of the buy-in programs themselves would rest with the Health Care Financing Administration (HCFA) within the Department of Health and Human Services (HHS). As with CHIP and Medicaid, states would submit a plan to the Secretary of HHS. Upon approval of the plan, each state would become eligible to receive tax credit funds directly from the federal government on behalf of eligible families. I am not aware of any examples of situations in which an individual tax credit can be claimed directly by an institution on the individual's behalf, but this seems a plausible arrangement.

PROGRAM DETAIL

Eligibility

This program is best viewed as an optional state-designed and -administered purchasing vehicle for low-income families eligible for a new federal tax credit that they can apply towards health insurance.

State responses are likely to fall into three categories Some states may take a minimal approach to implementation, and develop a zero-premium plan for families eligible for the full federal tax credit. Program eligibility would be limited to these families, and the program would require no premium collections. From the state's perspective, once these families are enrolled, they would be treated much like other families in CHIP or Medicaid.

Other states might take a moderate approach to implementation, and open their plans to families that receive only a partial federal tax credit. These families would have to pay the balance of the premium themselves. While this would necessitate premium collections, it would require no premium subsidies by the state.

Finally, a third group of states might use their own funds to subsidize the federal tax credit or to extend eligibility to families with incomes above the level at which the federal tax credit phases out. Such states would use funds to subsidize coverage for all families. Experience with Section 1115 waivers suggests that relatively few states would be likely to take this expansive approach in the first years of the program. However, if successful models emerge, this might become a more attractive option later on.

In all three cases, eligibility would be determined by a state agency—presumably the Medicaid or CHIP agency—based upon a state-designed application. Since the federal tax credit would be tied only to family income and purchase of health insurance, there would be no reason for the state to require information on matters other than income. If the state wished to place other restrictions on eligibility, such as the unavailability of employer-sponsored coverage, it would be able to do so.

Covered Benefits

Under the program described here, states would most likely offer benefits comparable to those provided by Medicaid and CHIP. CHIP seems the more likely model, since states have already grappled with the issue of how to design a benefit package that would benefit the non-welfare population. However, CHIP benefits were designed for children, and the buy-in option would have to address the rather different health care needs of adults. Therefore, while the premium cost-sharing, copayment structure, and general nature of benefits for the buy-in program are likely to resemble those in the state's CHIP program, the actual list of covered services may be somewhat different.

I have emphasized an option that allows people to buy into the Medicaid or CHIP programs, but there is no particular need for it to be identical to either of these programs.

For example, if the value of the federal tax credit is less than the state's current costs per enrollee in Medicaid or CHIP, the state might develop a more limited benefit plan, so that eligible families would be able to enroll in some form of health insurance without having to pay anything. If the credit is worth more, the state could even expand benefits.

It is difficult to predict how states would design their benefits given a tax credit of $2,000 per individual and $4,000 per family. In 1995, Medicaid expenditures per adult exceeded $2,000 in 15 states.[10] This would suggest that some states would be unable to offer a no-cost plan without making significant modifications to existing Medicaid benefit packages. But these data do not contain enough information to predict what insurance for the currently uninsured will cost compared to Medicaid. The risk profile of tax credit users compared to current Medicaid enrollees will have an effect on the benefits that can be covered.[11] The newly insured may have pent-up demand for services. At the same time, Medicaid adults include a disproportionate share of pregnant women, who cost more, compared to the general uninsured adult population. Finally, Medicaid coverage is defined at the individual level, while the tax credit would be available for families, making comparisons between the two systems difficult.[12]

It is legitimate to ask whether the buy-in option would be attractive if the tax credit fell short of the cost of the existing Medicaid benefit package. But the more appropriate question is how the buy-in option compares with what people are likely to find in the non-group market. Premiums for single adults with employer-sponsored coverage averaged almost $2,000 in 1996.[13] In two-thirds of the states for which data are available, Medicaid expenditures per adult recipient in 1995 were less than or equal to employer-sponsored single coverage in 1996. Medicaid costs are even more favorable if they are compared to the non-group market. Therefore, while the tax credit may not entirely finance existing Medicaid and CHIP benefit packages, they seem preferable to the non-group market where most people might otherwise use them.

What states do will depend partly upon the existence of other coverage options for this population. For example, a state with a generous Medicaid spend-down program and strong systems of health care providers that deliver free or subsidized care may prefer to scale back the buy-in benefits and let other parts of the health care system pick up the uncovered population. A state with a less generous health care system may use its own funds to expand buy-in benefits, so coverage in that program is comprehensive. Of course, the willingness of different states to use their own funds to subsidize insurance coverage for low-income people will vary, and will strongly influence the approach taken.

Plan Choice

The simplest approach is for states to place all buy-in enrollees into the same managed care plan with CHIP or Medicaid enrollees within a given geographic area. This simplifies enrollment and health plan relationships. However, in states that offer Medicaid enrollees a choice of plans, there is no reason those same choices should not be made available to buy-in participants. Enrollee choice, as long as benefits are standardized, thereby minimizing concerns about risk selection, can help assure quality. In addition, choice will make the buy-in option more attractive. Therefore, it makes sense for states to provide their buy-in enrollees with the same choices they give other public program participants.

A more complex option is for states to operate more like private purchasing cooperatives for their buy-in participants. In this case, the state would contract with multiple health plans, perhaps including plans that do not participate in Medicaid or CHIP. States also might select plans with different premiums, and pass on the differential to the buy-in participants. Since this model functions like a purchasing cooperative, except that in this case the cooperative is publicly administered, I leave discussion of the merits of this option to Curtis, Neuschler, and Forland.[14]

REGULATION

Underlying the tax credit approach is the assumption that individual purchasers will make decisions appropriate to their own needs without significant additional regulatory oversight of the market. Since the buy-in program offers consumers an additional option, there is no reason for the federal government to regulate the state buy-in program any more than it regulates the private insurance companies that offer plans to the public.

However, one important feature of the buy-in design places the state in a different position from other parties. As discussed above, the state can determine eligibility for benefits. Federal oversight of the enrollment process is warranted, since the state's actions can lead directly to the federal government having to make payments to the states.

A separate regulatory issue arises concerning the relationship between the applicant and the state. It is possible that the state could unduly influence an applicant's decision to participate in the buy-in program, rather than to use the tax credit in the open market. Therefore, some federal regulation is appropriate to ensure that the state-administered program makes it clear to the applicant that the buy-in is only one of a number of options.

DESIGN DETAILS AND ISSUES

Program Coordination

Enlisting the states as partners in implementing the tax credit provides some benefits for other programs. Enrollment in Medicaid and CHIP may become more appealing for families if they know that coverage will continue as their income changes. Similarly, parents may be more likely to enroll their children in CHIP or Medicaid if coverage for the entire family is available from the same source. Just as the Earned Income Tax Credit required a public campaign to expand its use, a health care tax-credit campaign may be necessary, and it easily could be coordinated with similar campaigns for CHIP that are currently under way.

From a programmatic perspective, coordinating the buy-in option with other programs such as CHIP and Medicaid would not be complex. Since an individual is not eligible for the tax credit if he or she is enrolled in CHIP or Medicaid, the buy-in process can simply screen for enrollment and decline those who are already in one of these other programs.

Some families may have difficulty understanding their options. A family in which one or more children is enrolled in CHIP or Medicaid may want to consider disenrolling from the public program to purchase non-group family coverage using the federal tax credit. This is an odd possibility to contemplate, but one that is implicit in the tax-credit design. The buy-in option actually makes the issue easier for the family because it creates an option that is not disruptive while making family coverage a possibility.

Enrollment

Families would have the option to buy into the state plan, or to use their tax credit in the private market. Families have three reasons to take advantage of the buy-in option. First of all, income qualification would be determined in advance, so there would be no risk of retrospective reconciliation or year-end payments to the government. Secondly, the delivery system is the same as that for Medicaid and/or CHIP, so families moving in and out of eligibility for those programs will retain continuity of coverage and caregivers. Finally, the choices available to families are structured, avoiding the complexities of negotiating the non-group insurance market. While all of these benefits would be available to families of all incomes, I assume they would be most appealing to those at the lower end of the income scale.

It is difficult to imagine a tax credit that does not operate with full year-end reconciliation, as occurs with the Earned Income Tax Credit (EITC). The IRS has only

one vehicle for reconciliation—the year-end tax return. The actual credit would be calculated at that time, and all payments or credits during the course of the year would be based upon estimates designed to smooth cash flow. However, the value of the credit would be known only at year-end.

In order for lower income families to find the tax credit a sufficiently strong incentive to make large health insurance payments during the year, they must be assured that they will not face a large year-end bill based upon changing financial circumstances. Therefore, it is essential that the state buy-in program be designed with family costs determined at the time of application, with no possibility of retroactive consideration, except in cases where incorrect or fraudulent information has been given.

It is likely that children in many of the families that would benefit from the buy-in program are already on CHIP. Now their parents would be able to use the tax credit to purchase their way into the same HMO or other delivery system the children are already using. This benefit is difficult to quantify, but is particularly important to consider in the context of outreach efforts currently being implemented in the CHIP program.

The tax credit would not be available to people with employer-sponsored health insurance. Therefore, this state buy-in option would be the only alternative to the non-group market. Non-group coverage has extremely high administrative costs and, even with relatively strong market rules, only moderately effective risk pooling. The state buy-in may offer the family more value for its money than the non-group market. Of course, the possibility that the program will be stigmatized as "welfare-like" may offset any benefits to the family.

Low enrollment in this program could reflect either of two possibilities: The state may not be running a very effective program, or the private market may be functioning so well that no one views the state program as desirable. Poor state administration could mean complex enrollment processes, poor advertising of program availability, limited benefits relative to the private market, or a network of providers viewed as low quality.

Yet, buy-in program enrollment alone is the wrong basis for judging the program's success. The overall goal of the tax credit, with or without the buy-in option, is to reduce the number of people without health insurance. If that happens, regardless of where people enroll, the program will have been a success. Certainly, if enrollment in the buy-in program is very low, the state may choose to drop it. If that occurs, the loss to families will be small.

Crowd-Out

Tax credits are not a particularly efficient strategy for reducing the number of people without health insurance, because some of the credits will be used to reduce current contributions made by employers or premium payments made by insured people. Therefore, the program must be designed to maximize the likelihood that currently uninsured people will use it to buy coverage. The most significant factor for most families will be the value of the credit, but an important second factor will be the choice of insurance products and their prices. A full discussion of how much of the credit will simply substitute for existing coverage is beyond the scope of this paper. However, the buy-in option should increase the appeal of the tax credit for the lowest-income beneficiaries, thereby improving the efficiency of the overall approach.

A different kind of crowd-out is the possibility that *states* will reduce their financial responsibilities at the expense of the federal government. People are not eligible for the tax credit if they are *enrolled* in Medicaid or CHIP. If this definition is taken literally, a family can pull its children out of Medicaid or CHIP, receive a tax credit for them, and purchase family coverage. From a family's perspective, this may or may not be a good deal—depending upon the size of the credit, the availability of non-group family coverage, and the quality of the Medicaid or CHIP program. But from the state's perspective, this swap is an unambiguous gain. Some or all of the members of the family move from a program that has a state match to a federally funded tax credit.[15]

Of course this issue arises with the tax credit in general, not just with the buy-in option—although the concerns may be greater with the buy-in. If the state has a financial incentive to move families from Medicaid to the tax-credit funded system, they may design a buy-in option specifically targeted at currently enrolled Medicaid families. In the end, this strategy is probably easier to imagine than to design. Still, the possibility that states might shift some of their financial responsibility to the federal government should not be ignored.

A simple response would be to reduce the federal Medicaid grant to states for each person who claims the tax credit but also appears, based upon the limited information available on a tax form, to be eligible for Medicaid.[16] The problem with this approach is that there are many Medicaid-eligible adults and children who are not enrolled. If the tax credit achieves its objective of drawing from the currently uninsured, the state will lose funds even though it experiences no savings in its Medicaid program. An alternative approach might be to reduce the federal grant only if Medicaid rolls decline. Unfortunately, the appropriate measure of the savings to the state is the difference

between actual Medicaid costs and what they would have been without the tax credit. This cannot be measured solely by counting falling Medicaid caseloads.

It will be difficult to measure precisely how many of the costs associated with the tax credit come from savings in Medicaid. Similarly, it will be highly controversial and difficult to measure how much the tax credit has reduced private contributions towards health insurance (the traditional notion of crowd-out) and cost-shifting to private payers for uncompensated care. If the tax credit successfully reduces the number of uninsured, it will have achieved its goal. Along the way it may also reduce costs for some other parties (individuals, providers, employers, states). There is no practical way to recapture all of these savings and it may be unproductive to attempt to do so.

Selection

This program will be subject to the risk of adverse selection, like any insurance product in a voluntary market. The degree of selection will depend largely upon how the non-group market functions. At one extreme, if the non-group market is fully community rated, there is no reason to think anyone would join the government program instead of the non-group market for reasons related to risk. At the other extreme, a non-group market that prices on the basis of risk will not appeal to high-risk individuals, and they will have an incentive to enter the community-rated state program. One could even imagine all participants in a state's high-risk pool shifting over to the buy-in program if it were available to them.

It is impossible to predict how much adverse selection will occur in the buy-in program. The most straightforward response to this concern is to pair the tax credit with reforms in the non-group market. However, the tax credit is a federal program, and non-group regulation is under state control. A federal requirement that states amend their insurance rules would certainly be controversial. The factors that make selection more or less likely—rating and underwriting practices in the non-group market, the health status of those eligible for the tax credit, and the quality of the buy-in insurance product—all vary across states. This suggests that, in the absence of federal rules, the likelihood and degree of risk selection will also vary across states.

One possible policy response is to erect barriers to keep high-risk individuals from shifting into the buy-in program. Waiting periods, or exclusions from the program if other sources of coverage are available, could address some of the selection problem. Such policies have been employed in other government programs and could apply here. They create some administrative complexity and deny coverage to some needy people, but they

may ease fears of adverse selection. Another form of barrier is to scale back the benefit package or use tightly managed care, making the buy-in program less attractive to a high-cost population. But these barriers might make the program less desirable for other people as well.

An alternative is to try to redirect dollars currently used to pay for health care services for those at high risk into the buy-in program, if people shift into it. The high-risk population can be found in state high-risk pools, in Medicaid spend-down programs, at the upper end of the non-group market, and among the uninsured paying out of their own pockets and sometimes creating uncompensated care burdens for providers. It should be possible to redirect funds from high-risk pools if demand for those programs shrinks substantially. Medicaid funds do not need to be reallocated, since that population is already relying upon public funds. However, if there is a wholesale shift of people from the high-cost end of the non-group market into the buy-in program, there is no straightforward way to capture those costs.

While these are serious concerns, they must be put in the context of the broader possibility that the tax credit, especially if its value is not sufficient to cover the cost of an insurance policy, will primarily attract higher risk people. If this happens in a state with restrictions on underwriting and risk-based rating in the non-group market, prices for everyone in that market will rise. If it happens in a state where the non-group market does not have these regulations, those interested in using a tax credit will find no one willing to sell them policies. Thus, concerns of risk selection are not restricted to the buy-in program and they should not lead us to reject the buy-in option. They are integral to the tax-credit approach, and should be addressed in that context.

Competition with the Private Sector

One concern with this model is the possibility that state governments will be viewed as competing with the private health insurance market. Certainly this program could siphon some people out of the non-group market. Risk selection issues aside, it is difficult to view this negatively. People will participate in this program only if they consider it a better value than the non-group market. If that is the case, the benefits of providing health insurance to low-income families will be greater. That seems a more important concern than whether newly insured families primarily gain their insurance through the state or through the non-group market.

Insurance companies and agents may view this issue differently. Insurance firms are unlikely to be affected, since Medicaid has moved from being primarily a fee-for-service

program to one that largely contracts with private managed care companies. While companies might prefer not to have the state as an intermediary between the enrollee and the plan, the business of insurance would remain in the hands of insurance companies, without competition from the public sector.

For insurance agents, the tax credit could mean a large, new clientele, but if people go to the state rather than the agent, that business will be lost. This is a legitimate concern, but if the private market functions well, and provides new, valued options to this low-income population, presumably most of the business will flow into the non-group market. If, on the other hand, people do not feel that the options in that market are desirable, they will consider the state buy-in program.

The politics of this issue will be significantly more complex if program benefits and administrative costs are less than the value of the credit, and there is a sense that states are skimming a portion of the federal tax credit. If administrative costs are comparable between private insurance and the public program, this cannot occur because the private sector would compete effectively with the public program. But non-group administrative costs are high, and a state program that builds upon an existing Medicaid infrastructure may have much lower costs. Because the value of the tax credit will be low, it is difficult to imagine this occurring, but it is a risk that must be avoided.

KEEPING THE PROGRAM CURRENT

The value of the tax credit would presumably be scaled to meet the typical cost of a non-group insurance policy. However, the buy-in option would become less desirable the further that credit fell below the state's costs of delivering the benefits under Medicaid or CHIP. If the credit were worth less, and the state wanted to keep its program simple by providing a zero-premium option, the state would either have to subsidize the credit or offer fewer benefits than Medicaid. The first option is simple, but expensive. The second option adds significant complexity and partly reduces the purpose of the buy-in option. These alternatives are not terribly important for the population above 200 percent of the FPL, because some premium cost-sharing is expected. But for the lower-income population—the target of this program—these issues are significant. Therefore, regular updating of the value of the tax credit to reflect market conditions will be important for the buy-in option to succeed.

THE PROGRAM FROM THE ENROLLEE'S PERSPECTIVE

A potentially eligible person would apply at the county social services agency or any outreach organization the state designated, as states have for CHIP. The application would

require information on earnings, enabling the state and the federal government to determine the estimated tax credit available to the applicant for the balance of the tax year. The state would indicate to eligible applicants that insurance is available at the price set by the state, taking into consideration the federal subsidy the state expects to receive. From that point, the applicant would be treated like any other enrollee in a state-administered insurance program.

To avoid the possibility of gaming, and to reduce administrative complexity, a family could not enroll in the buy-in for one part of the year while claiming the tax credit for another part of the year. State collection of the tax credit on behalf of eligible families would occur on a monthly enrollment basis, so mid-year enrollment would simply affect the number of credits claimed by the state.

There is always a difficult trade-off between requiring families to enroll at a specific time, which reduces risk selection, and allowing enrollment at any time, which encourages greater participation. As a practical matter, mid-year enrollment is likely to occur when a person appears at a medical facility and that facility, desiring payment, seeks to enroll the person in a plan. If the buy-in program relies upon managed care contracts, plans will demand a higher capitation rate if mid-year enrollment is allowed, since they receive no payment during the period the person is not enrolled. Whether people, and the providers who serve them, should pay for the fact that some people do not enroll in a free or near-free program even when it is available to them, is a decision that involves balancing values and practical realities. Since the buy-in is just one part of a broader set of social policies set by the states, and since the program is optional, I would be inclined to let each state decide whether enrollment could occur at any time or just during an annual open enrollment period.

MEASURING SUCCESS

The most basic measure of the program's success is the degree to which the tax-credit program, with the buy-in option as one component, reduces the number of people without health insurance. A measure of the buy-in's success in particular should be the degree to which the program keeps families intact as an insurance unit. Assuming that it is at least somewhat successful in this regard, the program will also be a good source of data for determining if there are utilization and health outcome advantages for families that have a single source of coverage.

PROGRAM WEAKNESSES

A program that provides states with flexibility in design is always subject to the criticism that similarly situated children and families will be treated differently depending upon where they live. This seems a particularly weak criticism in the context of a tax credit, because insurance markets already vary so much around the country. Even without state flexibility, the credit will have tremendously varying benefits for people in different parts of the country.

A second criticism of state-flexible programs is that it is difficult to estimate costs prospectively. This is especially true when there is no cap on the federal outlay. But the state option merely affects the take-up rate of a program to which all people are entitled. States do not receive any more money from the federal government than the federal government would be paying to individuals eligible for the tax credit. Therefore, while it is difficult to know precisely how this program would look upon implementation, the cost consequences of the buy-in option should be modest. If tax credit outlays are higher than anticipated, this would merely demonstrate how difficult it is to project the costs of a broad tax credit, and should not be used to criticize the buy-in option itself.

CONCLUSION

The health insurance tax credits that have been proposed are significantly different from tax credits already in use. The EITC has the fairly straightforward goal of subsidizing the earnings of low-income families, while the dependent-care credit subsidizes a small share of a family's cost for a broad set of services.[17] Proponents of the health insurance credit have more ambitious goals. First, they hope to substantially increase demand for a specific product among low-income people, something that no other credit has attempted to do. Second, they plan to apply it in the arena of insurance, where incentives for risk segmentation are extremely strong and can unravel any benefit created. Third, except in the most ambitious proposals, the credit would complement an already-existing entitlement for children and some adults with very low-income.

There is no doubt that tax credits can shift incentives on the margin. If designed correctly, they can also equitably assist those who are viewed as engaging in socially beneficial behavior. These reasons, combined with their broad political appeal, given the current fiscal situation and budget rules, suggest the tax-credit option should be taken seriously.

Only a few states have made subsidized health insurance coverage available to a significant portion of their population with incomes higher than the Medicaid population.

This partly reflects how cumbersome the Section 1115 waiver process can be to negotiate. In addition, few states have been willing to commit large sums of money to subsidize coverage for this group out of tax revenues. While the buy-in option presented here is designed as an add-on to a tax-credit proposal, it could easily stand alone. That is, federal funds could be made available directly to states to develop and/or expand sliding-scale buy-in programs. This alternative has the advantage of building upon a model some states have tested and refined. It has the disadvantage of expanding insurance coverage through a public program rather than the private non-group insurance marketplace.

Tax credit proponents should pay as much attention to the insurance market for tax-credit–eligible families as they do to the intricacies of the credit s value and the circumstances under which it is available. If, as in Zelenak's proposal, the credit cannot be applied towards employer-sponsored coverage, the credit must be taken to the non-group market. This market operates with varying effectiveness in different states, but always has high administrative costs and is more volatile than the employer-based market.

It is worthwhile to consider how the non-group market can be improved. It is equally important to ensure that those who cannot navigate this market or who are not served well by it—or who find it too different from the health care system they have used thus far, and feel uncomfortable making large payments into it—have a place to go. The buy-in option presented here provides that essential safety valve. It expands the value of the tax credit, not monetarily, but in other ways that may be just as important. It is a critical feature of any tax-credit plan.

NOTES

[1] Kaiser Family Foundation. 2000. "Uninsured in America: A Chart Book, May 2000." http://www.kff.org/content/archive/1407/ (Accessed July 20, 2000).

[2] Health Care Financing Administration. 2000. "The State Children's Health Insurance Program: Preliminary Highlights of Implementation and Expansion." www.hcfa.gov/init/wh0700.pdf (Accessed July 20, 2000).

[3] Kaiser Commission. 1999. "Medicaid Facts: Medicaid and Managed Care." http://www.kff.org/content/archive/2068/medicaidmanagedcare.pdf (Accessed July 20, 2000).

[4] Larry Zelenak. *A Health Insurance Tax Credit for Uninsured Workers.* The Commonwealth Fund. December 2000. (One of this series.)

[5] Melora Krebs-Carter and John Holahan. 2000. "State Strategies for Covering Uninsured Adults." Washington, D.C.: The Urban Institute. *Assessing the New Federalism* Discussion Paper 00-02.

[6] Medicaid eligibility levels for children are set through a combination of federal and state policies, while CHIP eligibility levels are at state discretion. In most states, public coverage for children is available up to incomes between 185% and 250% of the FPL. By contrast, Medicaid coverage for non-disabled adults is almost entirely limited to pregnant women and parents of children receiving cash assistance (TANF), for which income standards vary by state, with the median state offering coverage only up to 60% of the FPL. I use the 200% of the FPL break because it is representative, while actual values vary by state.

[7] Lisa Dubay, Genevieve Kenney, and Stephen Zuckerman. 2000. "Extending Medicaid to Parents: An Incremental Strategy for Reducing the Number of Uninsured." Washington, D.C.: The Urban Institute. *Assessing the New Federalism* Policy Brief B-20.

[8] John Holahan and Niall Brennan. 2000. "Who Are the Adult Uninsured?" Washington, D.C.: The Urban Institute. *Assessing the New Federalism* Policy Brief B-14.

[9] In order for states to bear the risk, individual tax returns must be reconciled for families that choose the buy-in option, and the difference between those reconciled values and the payouts to states computed. This raises a few concerns. One is that families will not understand that the reconciliation information is only being used to compute their state's liability, not theirs. In addition, some buy-in participants will certainly fail to complete the reconciliation process (by not filling out a tax return or not filling out the appropriate portion). It seems inappropriate to penalize the state for this behavior, but risky to ignore it. In the end, prospective eligibility determinations by the states within federal standards is likely to be the best of the three options.

[10] David Liska, Niall Brennan, and Brian Bruen. 1998. *State-Level Databook on Health Care Access and Financing.* Washington, D.C.: Urban Institute Press.

[11] If the state chooses to contract with managed care plans, what the plans *think* the relative risks of these two populations may be is more important than what the actual differences are. This is because plans will bid based upon their expectations. Over time, expectations and reality should converge, but at the outset they may be quite different.

[12] There are other data issues as well. Medicaid enrollment in the reported data include anyone enrolled at any time during the year, not at a point in time. This makes per-enrollee costs lower than they would be if they were calculated on an average caseload basis. If tax credits make enrollment more stable so people are covered while they are sick and while they are healthy, the Medicaid data as reported may be the appropriate comparison. If buy-in participation involves as much churning as Medicaid, per-person costs will be higher and states will not be able to afford as comprehensive a package of benefits.

The family structure of new tax-credit users may differ from that of the existing Medicaid or privately insured population. Since the credit is a flat amount per family, family structure will affect how far the credit will go towards purchasing insurance. Average Medicaid costs per child are low, relative to adults, but without knowing the family structure of tax-credit users, we cannot know what it would cost to provide the Medicaid package to those families. In addition, CHIP benefits may be less expensive than Medicaid benefits, but systematic cost data are not yet available on this program.

[13] James Branscome, Philip Cooper, John Sommers, and Jessica Vistnes. "Private Employer-Sponsored Health Insurance: New Estimates by State." *Health Affairs* 19 (January/February 2000): 145.

[14] Richard Curtis, Edward Neuschler, and Rafe Forland. *Private Purchasing Pools to Harness Individual Tax Credits for Consumers.* The Commonwealth Fund. December 2000. (One of this series.)

[15] An intuitively appealing way to address this possibility is to bar those who are eligible for public coverage, not just those who are enrolled, from the tax credit. But this would be impossible to administer through the tax code, since the tax return does not have sufficient information to determine an individual's eligibility for Medicaid or CHIP.

[16] As noted above, Medicaid eligibility cannot be determined based upon information on a tax return. An approximation is not good enough if we are interested in determining whether or not an individual should be eligible for the credit. However, a reasonable approximation could be made if it was solely for the purpose of determining how much money states have saved by shifting their Medicaid costs to the federally funded tax credit.

[17] To some, the EITC also has the goal of increasing work effort—a goal more similar to what health insurance tax credits are supposed to accomplish. However, the fact that earnings are a continuous variable, while health insurance is much more discrete (you either have it or you don't), makes the dynamics of the incentives created by these two credits quite different.

RELATED PUBLICATIONS

In the list below, items that begin with a publication number are available from The Commonwealth Fund by calling our toll-free publications line at 1-888-777-2744 and ordering by number. These items can also be found on the Fund's website at www.cmwf.org. Other items are available from the authors and/or publishers.

#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.

#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.

#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.

#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.