CHALLENGES AND OPTIONS FOR INCREASING THE NUMBER OF AMERICANS WITH HEALTH INSURANCE

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EXECUTIVE SUMMARY

Despite our booming economy, nearly 43 million people—or one-sixth of the U.S. population—still lack health insurance coverage. People without insurance risk not only dire health consequences, but also financial disaster if they become very sick.

Helping the uninsured gain coverage should be a public policy priority. With this in mind, The Commonwealth Fund Task Force on the Future of Health Insurance commissioned 10 experts on different aspects of health insurance policy to investigate different proposals for expanding coverage.

The Task Force commissioned papers dealing with insurance for working people that lack access to both employer-based coverage and publicly funded coverage. Many of these families have incomes that are low, but still above 100 percent of the federal poverty line. However, this is a diverse population with complex needs. Uninsurance rates are highest among young adults, employees of small firms, and the near poor, but significant numbers of the uninsured fit into none of these categories.

The uninsured population is constantly changing, as people gain and lose insurance coverage and—even when they remain uninsured—move among different subgroups within the uninsured population. Because illness often cannot be anticipated, people with even short spells without insurance can have significant problems gaining access to, and paying for, care. This population is particularly difficult to serve, since its members have less time and incentive to learn about programs and need to join and leave programs at different points during the year.

Other subgroups of the uninsured population pose additional challenges, including those nearing retirement age and people in poor health who often cannot rely on the individual market which is very expensive and may even refuse to insure high-risk people. Community-rating or age-band limits would bring down average premiums for high-risk people, but they may then drive many low-risk people out of the insurance pool. This could cause the health insurance market to disintegrate if insurance plans fail to attract enough healthy people to stay in business.

Immigrants also have trouble gaining access to insurance and now make up 20 percent of the uninsured. They often take low-paying jobs that do not provide coverage. Noncitizens are also typically ineligible for public programs, and cannot afford the high premiums for non-group insurance. Finally, many Americans remain uninsured, even if they are eligible for public programs. Many people fail to participate in public programs because they do not know about them or because enrollment procedures are too complicated.

This overview paper describes 10 policy options that aim to address these concerns. These options fall into five categories:

- Expansions of public health insurance programs such as Medicare, Medicaid, and the State Children's Health Insurance Program (CHIP);

- Individual premium assistance such as tax credits or vouchers that could be used to purchase insurance by those qualifying on the basis of income or other characteristics;

- Purchasing pools through which qualifying beneficiaries could buy insurance, and which would offer the advantages of group insurance programs to individual recipients;

- Incentives that encourage more employers to offer insurance, and

- Proposals that focus on specific groups such as people who are over 55, but not yet eligible for Medicare, and people who lose insurance when they are between jobs.

All of these options have advantages and disadvantages, and the best approach may be to implement some combination that draws on the strengths of all of them. For example, individual tax credits or premium assistance may make non-group insurance more affordable for many people. However, many people also find it difficult to navigate the non-group market, so incentives must be coupled with aggressive measures to make plan enrollment and reenrollment easier. For example, some programs might work with employers to encourage qualifying beneficiaries to sign up for insurance. New purchasing pools could provide information and simplified enrollment procedures for qualifying beneficiaries. Expanded public programs could reach out to past participants in Medicare, CHIP and TANF, many of whom would be eligible for the new incentives.

Pools of all kinds, including expanded public programs may reduce insurance costs and make administration easier, but they risk adverse selection if people at low risk still find the non-group market more attractive or remain uninsured. One way to reduce adverse selection against pools would be to establish public reinsurance pools, paid for by the federal government, for those at very high risk. This would simultaneously lower premiums for all those who remain in the pool, and attract insurers to participate in the pool. Another possibility would be to require qualifying beneficiaries to purchase coverage

through pools. Finally, special coverage or premium assistance arrangements could be targeted to serve high-risk groups, such as those over 55.

All programs that target expansions to subsets of the population must have some phase-out mechanism for premium assistance based on incomes. But phaseouts add new elements of complexity and incentives for those near the margin of the phase-out ranges.

The challenges of incremental reforms are linked in a way that makes it impossible to solve them all at once. Increased participation comes at the price of reduced targeting. However, participation is the most important consideration. In addition, people in similar situations should be treated in similar ways. Any new programs should also provide the maximum possible benefit to those in need. Mitigating specific issues such as timing, targeting, crowd-out, and selection should be thought of as means to these ends, not ends in themselves.

Table ES-1
Expert Papers Commissioned by
The Commonwealth Fund Task Force on the Future of Health Insurance

Larry Zelenak	*A Health Insurance Tax Credit for Uninsured Workers*
Katherine Swartz	*Markets for Individual Health Insurance: Can We Make Them Work with Incentives to Purchase Insurance?*
Richard E. Curtis, Edward Neuschler, and Rafe Forland	*Private Purchasing Pools to Harness Individual Tax Credits for Consumers*
Beth C. Fuchs	*Increasing Health Insurance Coverage Through an Extended Federal Employees Health Benefits Program*
Alan Weil	*Buying into Public Coverage: Expanding Access by Permitting Families to Use Tax Credits to Buy into Medicaid or CHIP Programs*
Mark Merlis	*Public Subsidies for Required Employee Contributions Toward Employer-Sponsored Insurance*
Jack A. Meyer and Elliot K. Wicks	*A Federal Tax Credit to Encourage Employers to Offer Health Coverage*
Sara Rosenbaum, Phyllis C. Borzi, and Vernon Smith	*Allowing Small Businesses and the Self-Employed to Buy Health Care Coverage Through Public Programs*
Pamela Farley Short, Dennis G. Shea, and M. Paige Powell	*A Workable Solution for the Pre-Medicare Population*
Jonathan Gruber	*Transitional Subsidies for Health Insurance Coverage*

CHALLENGES AND OPTIONS FOR INCREASING THE NUMBER OF AMERICANS WITH HEALTH INSURANCE

INTRODUCTION

Despite our booming economy, 43 million Americans or nearly one out of six of the United States population lacks health insurance coverage. The uninsured often cannot afford necessary preventive and curative care. Nearly half report that they failed to get medical attention for a problem in the previous year because of the costs of care (Budetti, 1999). Studies show that people who lack insurance face a higher risk of overall mortality, a higher risk of mortality from specific causes, and higher risks of serious medical problems (such as ruptured appendix) (Franks, Clancy, and Gold, 1993; Ayanian et al., 1993; Braveman et al., 1994). People without insurance not only face dire health consequences, but also financial disaster if they become very sick. It is estimated that the uninsured are twice as likely to go without needed care as are their insured counterparts. Nearly one-third of the uninsured say they have been contacted by bill collectors about unpaid medical bills (Budetti, 1999).

Helping the uninsured gain coverage should be a public policy priority. As a step in that direction, The Commonwealth Fund Task Force on the Future of Health Insurance commissioned a set of policy options for expanding coverage. Proposals considered here examine incremental insurance expansions, which are the focus of current efforts at the federal and state levels. Although incremental, the proposals consider development of new options that could provide a base to build on for future more comprehensive proposals. The Task Force commissioned 10 experts on different aspects of health insurance policy to investigate different proposals to expand coverage. This paper provides an overview of these specific policy options and discusses general issues confronting any effort to expand coverage incrementally.

The options described here extend previous work by others (see Henry J. Kaiser Family Foundation Project on Incremental Reform) to identify ways to insure the uninsured or unstably insured. The Commonwealth Fund Task Force commissioned papers that focus on the working uninsured, whose family incomes often fall above 100 percent of the federal poverty line. For example, a full-time worker paid the minimum wage earns about 133 percent of the federal poverty line for a single adult. The options described here are intended to reach the uninsured population with earnings at or above this level and, more generally, to provide more affordable insurance options for the working insured.

This paper comprises three sections. The first provides a profile of the uninsured under age 65 and describes the challenges of incrementally expanding coverage to different

groups within this population. The second section describes a set of basic principles that should be considered in evaluating options. The third section outlines three types of strategies for incremental expansion (expanding public programs, using individual incentives, and building on the employer base), as well as approaches that address the unique concerns of unemployed and older workers. This section synthesizes and summarizes the 10 papers commissioned by the Task Force.

SECTION I. WHO IS UNINSURED? THE CHALLENGES OF EXPANDING COVERAGE INCREMENTALLY

There are three main reasons why people may lack health insurance. First, most uninsured people's incomes are so low they cannot afford coverage. The average insurance policy covering a single employee under 65 cost $2,424, while a family policy cost $6,348 (in 2000) (Gabel et al., 2000). Employer-sponsored coverage is generally less costly than similar coverage purchased in the individual market. For nearly half of the uninsured, insurance coverage for a family would cost more than 25 percent of family income (see Table 1).

Table 1
Income Characteristics of the Uninsured Population Under Age 65

Income Category by Federal Poverty Level	Percent Uninsured in Poverty Group	Distribution of the Uninsured	Median Family Income of Uninsured in Group
<100%	39.0%	34.7%	$5,636
100%–199%	30.3	29.7	$18,324
200%–299%	16.7	15.9	$29,000
300%–399%	10.6	8.1	$41,035
400%+	6.3	11.7	$72,546
All Uninsured	18.4%	100.0%	$18,001

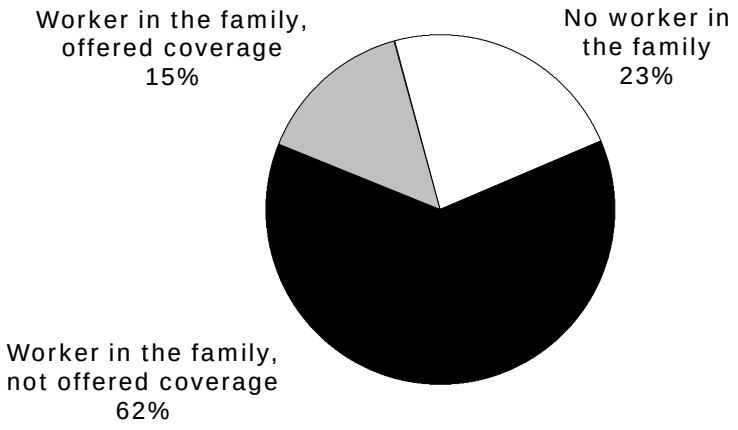
Note: Poverty estimates are based on related family members in a household that would typically be counted for purposes of an insurance policy or application for a public program. The income distribution includes all adults and children based on family income and size compared to poverty thresholds.

Source: Estimates by S. Glied et al., Columbia University, for The Commonwealth Fund Task Force, based on the March 1999 Current Population Survey.

Second, in today's market, private health insurance is most economically obtained through an employer, and over 90 percent of those with private insurance obtain it in this way. However, most uninsured people are not offered employment-based coverage directly or through a family member. Over three-quarters of the uninsured are members of working families (including dependents), but for 80 percent of this group, the worker's firm does not offer health insurance coverage (see Figure 1). Only 15 percent of the uninsured are in families where a worker is offered, but turns down, coverage.

Figure 1

Distribution of the Uninsured by Work Status and Access to Employer Coverage



Source: Estimates by S. Glied et al., Columbia University, for The Commonwealth Fund Task Force, based on the February 1997 Current Population Survey.

Finally, eligibility for public insurance programs is quite limited, especially for adults without children. Children in families with incomes below 100 percent of the federal poverty level are eligible for Medicaid in all states. In most states, however, a single adult with income as low as $4,000 a year would not qualify for Medicaid, and in the 11 states without programs for the medically needy, no non-disabled single adults under 65 can qualify for Medicaid (author's tabulations of Green Book, 2000).

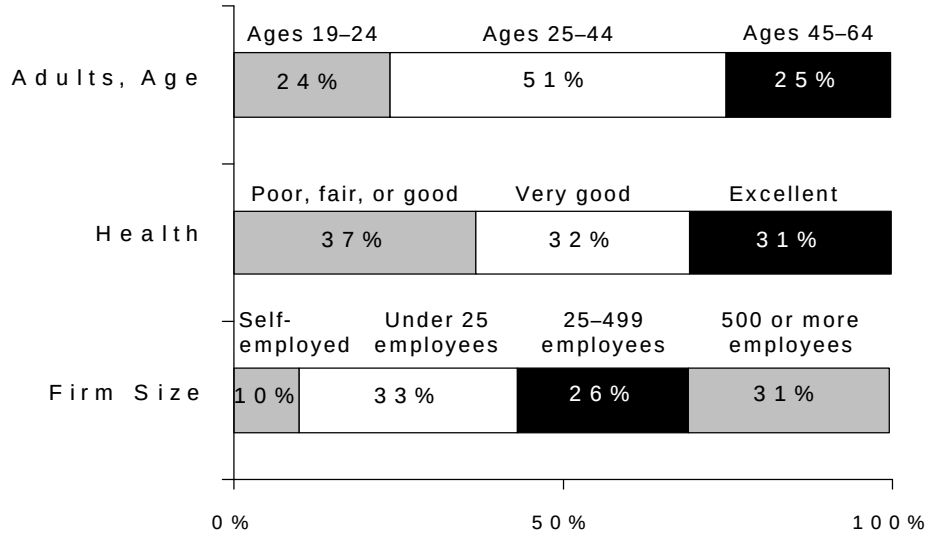
Challenges in Getting Coverage to the Uninsured

Most of the uninsured are low-income people who lack access to both employer-based coverage and public coverage. However, this broad generalization covers a diverse population with complex needs. Designing coverage options for this population requires a more precise understanding of its characteristics.

A sense of the diversity of the uninsured population is provided by some marked contrasts within it. Figure 2 divides the uninsured into groups of roughly equal size. Many of the uninsured (31%) are in excellent or very good health—but slightly more report that their health is less than very good. Many are young adults, but an equal proportion are age 45 or older, and many are nearing retirement age. The number who work in small firms is just slightly larger than the number who work in very large firms. Clearly, no single health insurance option will work for every one of these very disparate groups.

Figure 2

Uninsured Include a Diverse Group



Source: Estimates by S. Glied et al., Columbia University, for The Commonwealth Fund Task Force, based on the March 1999 Current Population Survey.

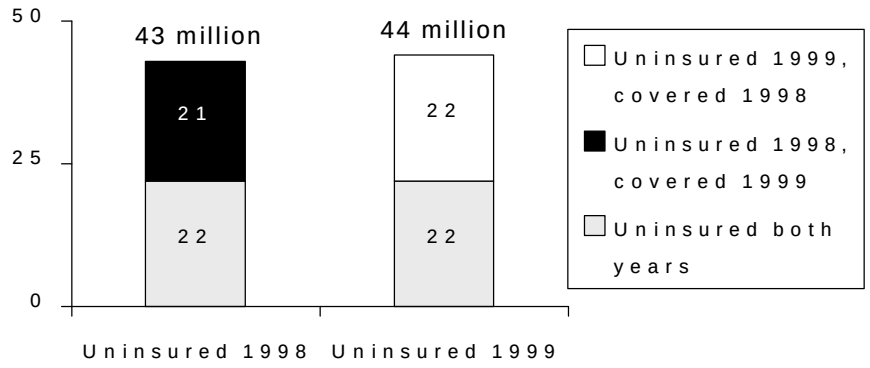
The uninsured population is also constantly changing. People gain and lose insurance coverage and, even when they remain uninsured, move among different subgroups within the uninsured population (Swartz, Marcotte, and McBride, 1993; Swartz and McBride, 1990).

Consider the increase in the number of uninsured Americans from 43 million to 44 million between 1997 and 1998 (see Figure 3).[1] Between 1997 and 1998, about 21 million previously uninsured Americans gained insurance coverage. Most of them (two-thirds) became privately insured through employment. An additional 22 million previously insured Americans lost insurance coverage. Most of them (two-thirds) lost private, employment-based insurance coverage. Many of the 22 million who were uninsured in both years also experienced substantial changes in their life circumstances. Seventeen percent of those who remained uninsured and had initially been employed in small firms moved to larger firms. Nearly 60 percent saw their income rise or fall by 50 percent or more.

[1] These figures are computed by matching the March 1998 and March 1999 Current Population Surveys (CPS) for the sample of the population that appears in both surveys. The matched sample is used to project the experience of the entire population. Note that this procedure is likely to understate the extent of transitions because those who are lost to follow-up and do not appear in the second wave of the CPS are probably more likely to have experienced a transition than are those who remained in the sample. The estimates are roughly consistent with Short and Klerman's analyses of the SIPP (Short and Klerman, 1998). They find that slightly over half of the uninsured in 1992–1993 were uninsured for 12 months or more.

Figure 3

Uninsured Dynamics: A Shifting Population



Source: Estimates by S. Glied et al., Columbia University, for The Commonwealth Fund Task Force, based on the March 1998 and March 1999 Current Population Surveys.

The year-to-year comparisons considered here mask even more short-term transitions in the population of the uninsured. About 28 percent of the uninsured spend less than 6 months without coverage, but an estimated 40 percent of the uninsured lack coverage for a period of 18 months or more (Short and Klerman, 1998). One key challenge is to find ways to help people avoid spells of uninsurance, perhaps by developing forms of coverage that allow people to remain insured as their circumstances change.

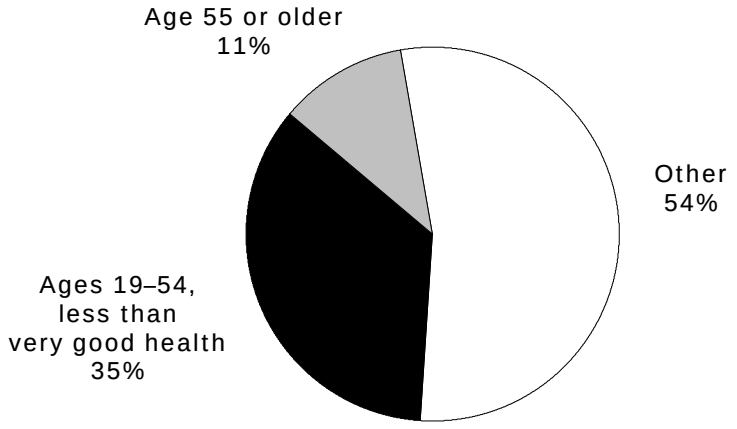
As these figures suggest, the number of uninsured people at any given time exceeds the number uninsured during an entire year. The Survey of Income and Program Participation, which tracks coverage over time and asks respondents about insurance at various intervals during the survey, has found that as many as 55 million Americans lacked insurance at some time during the year. Those who are currently insured but were uninsured earlier in the year resemble, both in their demographic characteristics and health services experiences, those who are currently uninsured (Schoen and DesRoches, 2000).

The transitory nature of insurance loss and gain poses serious problems for policy makers. In order to assist people who gain and lose coverage over relatively short periods, new programs must address issues of timing. New sources of insurance coverage must be made available for people who lose their current coverage, or else adults and their families must be somehow enabled to keep their insurance as circumstances change.

Because the uninsured population is constantly changing, it is difficult to target programs effectively to them. For example, programs that aim to improve targeting by limiting eligibility to those who do not now (or did not in the recent past) have access to employer-sponsored coverage will be undermined by the fact that a large (but hard to identify) fraction of the uninsured will eventually gain private coverage anyway.

Some subgroups of the uninsured population pose additional challenges. Private health insurers charge high premiums, or refuse to sell complete coverage, to those who are or can be expected to be in poor health. As Figure 4 shows, nearly 50 percent of the uninsured have less than very good health or are over age 55 and so at greater risk of developing poor health. While rating restrictions and insurance reforms seek to make coverage available to all, such reforms have been implemented in only a handful of states and rarely address affordability; when implemented, they may lead to serious unintended problems in the operation of the individual insurance market.

Figure 4
Uninsured Adults by Health and Age Risk

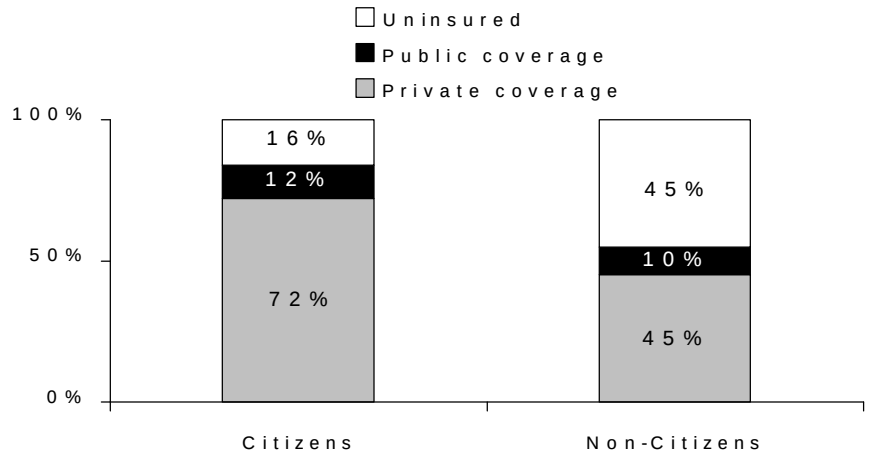


Source: Estimates by S. Glied et al., Columbia University, for The Commonwealth Fund Task Force, based on the March 1999 Current Population Survey.

Non-citizens make up nearly 20 percent of the uninsured population in the United States, and much higher fractions in several states. Most of these non-citizens are legal permanent residents in the United States. Rates of coverage are low among non-citizens partly because most are not eligible for most public programs. However, Figure 5 shows that differences in public coverage explain only a small part of the lower rates of coverage among non-citizens. Private insurance coverage among non-citizens is only two-

thirds as high as among citizens, although non-citizens are about as likely to work as are citizens (Quinn, 2000).

Figure 5
Distribution of Insurance Coverage by Citizenship Status



Source: Estimates by S. Glied et al., Columbia University, for The Commonwealth Fund Task Force, based on the March 1999 Current Population Survey.

The Take-Up Problem

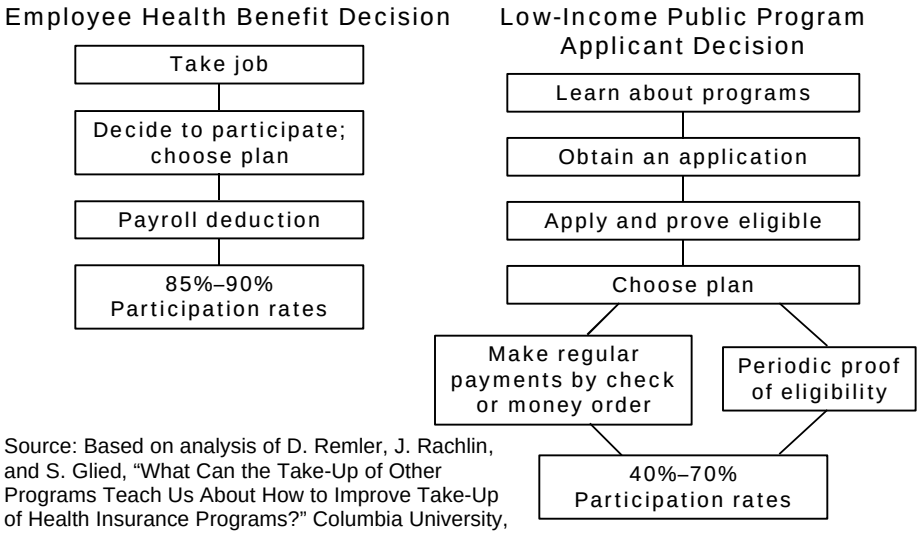
The most troubling subgroup of the currently uninsured comprises those who are formally eligible for some public insurance program, generally Medicaid or CHIP, but remain uninsured. Over one-quarter of all uninsured adults, and nearly two-thirds of uninsured children, appear to be eligible for public coverage on the basis of their income and family circumstances—a total of 15 million people (author's estimate). Income and family circumstances are not perfect proxies for the complex eligibility criteria of public programs, so this is likely to be an overestimate (Remler, Rachlin, and Glied, 2000). Nonetheless, it is clear that many eligible people do not take up free coverage or coverage at modest premiums.

We can understand why take-up rates for free coverage are so low, if we compare the procedure for obtaining public coverage with the process that most insured Americans go through to gain coverage (see Figure 6).

Figure 6

High Take-Up Rates of Employer Plans

Ease of Signing Up = High Participation



Source: Based on analysis of D. Remler, J. Rachlin, and S. Glied, "What Can the Take-Up of Other Programs Teach Us About How to Improve Take-Up of Health Insurance Programs?" Columbia University, Working paper, August 2000.

For most insured Americans, coverage is nearly automatic.[2] Take-up rates for Medicare are nearly 100 percent, largely because those who turn 65 are automatically enrolled in Medicare Parts A and B. Their social security payments are automatically reduced to cover their Medicare Part B premiums shares. They must take deliberate steps to turn down this Part B coverage. Once an individual is enrolled in these programs, reenrollment is automatic.

Take-up rates for employer-sponsored coverage average nearly 90 percent and nearly 100 percent for those who need not contribute to the cost of their own coverage. Those whose employers offer coverage are often automatically enrolled in a plan when they begin a job (or first qualify for coverage), unless they explicitly decline coverage. In almost all cases, employers select one or more plans for their employees, present employees with the required forms, and make any necessary payroll deductions. Once an individual is enrolled in an employment-based plan, reenrollment is nearly automatic. In most cases, employees must explicitly choose to opt out of coverage once they have enrolled.

In contrast, in order to participate in need-based public programs eligible individuals must, at a minimum, learn about the existence of the program; obtain application materials; apply to the program and demonstrate eligibility (which may entail a visit to an eligibility office to submit numerous documents verifying income, assets,

[2] Exceptions to this nearly automatic enrollment process are the 7% of insured Americans who purchase individual insurance.

citizenship, residency, age of children, and even job and employer); and in some cases, make periodic payments to an insurer. This multistage process requires uninsured people, most of whom are members of low-income families with many equally pressing demands, to take several often complicated steps. Failure at any stage means a continued lack of coverage. Reenrollment often requires proving eligibility again, with another round of forms, supporting documents, and eligibility office visits. In this context, the moderate take-up rates observed, even when premiums are heavily subsidized, are hardly surprising. In short, coverage through public health insurance programs for working people is typically neither automatic nor easy.

The substantial influence of nearly automatic enrollment mechanisms on take-up has been dramatically demonstrated in a recent study that focused on retirement contributions in a company that made a change to its payroll deduction policies for 401(k) plans (Madrian and Shea, 2000). Initially the company made payroll deductions only when employees specified a deduction level and chose a specific plan. After the change, the company automatically made a 3 percent payroll deduction and put it in a money market fund, unless the employee chose otherwise. As a consequence of this change from manual to automatic enrollment, the share of new employees contributing to 401(k) plans rose from 37 percent to 86 percent, with most of the increase among those making the default contribution and holding the default plan.

SECTION II: INCREMENTAL COVERAGE ISSUES AND OPTIONS

The characteristics of the uninsured raise several issues that will determine the likely success of alternative policy proposals. First, most of the uninsured are poor and will need substantial premium assistance in order to be able to afford coverage. Research shows that very-low-income people are much more likely to participate in a program that is free than in one that requires even modest contributions (Marquis and Long, 1995). For example, participation in new State insurance programs that use sliding-scale premiums is substantially lower when out-of-pocket premium shares are higher (Ku and Coughlin, 1999/2000). Participation appears to fall off steeply when premium costs reach or exceed 5 percent of income.

Second, as the above discussion of take-up suggests, generous incentives alone will not ensure that substantial numbers of the uninsured participate in a new program, nor will incentives alone keep people in programs. Premium assistance must be coupled with aggressive measures to make enrollment and reenrollment easier if participation is to increase.

Efforts to expand coverage incrementally must also consider ways to attract and contact the uninsured. Some approaches would use other programs and settings to find

potentially eligible families. For example, some states focus their CHIP enrollment efforts on families who already participate in other programs, such as food stamps or school lunch programs. States that build on existing program participation send application forms to all families with children enrolled in these programs.

Employers could also serve as conduits to the uninsured. Several existing programs, such as the Earned Income Tax Credit, require employers to provide information to potentially eligible employees. Employers could be mandated to provide information about the existence of health insurance programs. Employers could also be required to make payroll deductions on behalf of employees who chose to participate in a program. Similar mandates for payroll deduction already exist for child support payment and federal student loans in default.

A still more aggressive approach would be to automatically enroll the uninsured, and provide them with an option to turn down coverage if they wished. Automatic enrollment for the uninsured is complicated because they are so hard to identify. For example, many workers who do not obtain coverage from their employers obtain it through a spouse. It would be extremely difficult to provide automatic dependent coverage for two worker families. Nonetheless, the considerable advantages of automatic enrollment make it worth considering this path.[3]

Third, most of the uninsured have no natural venue in which to buy coverage. Premium assistance alone will enable them to buy coverage only in the individual market,

[3] In an employment-based automatic approach, employers could be required to file a form annually and whenever making a new hire. Using this form, employees would report their health insurance coverage status and report whether their family income was below a threshold that would probably make them eligible for subsidized coverage. Such estimates of family income are already used in filing W-2 forms. Employers would forward to a program office forms for all employees who reported that they did not hold health insurance coverage and that they were eligible for incentives. These employees would then be automatically enrolled in a public program. Any residual costs of coverage, beyond the subsidy, would be deducted by the employer through payroll deduction and forwarded to the program office. Employees enrolled in this way would be sent a form allowing them to (a) turn down coverage altogether; (b) substitute a voucher that could be used to buy into an employer plan; or (c) enroll one or more dependents in the public program. At the end of the year, the IRS would do an income reconciliation and adjust subsidy levels retrospectively.

Alternatively, automatic enrollment could be administered through the tax system. All tax filers could be required to report whether or not they held health insurance. Those who did not hold insurance would have the option of checking that they did not want coverage. Those who did not turn down coverage, and who met subsidy eligibility criteria, could be automatically enrolled in a purchasing pool, such as extended Federal Employees Health Benefits Program or in a public program. The additional costs of insurance, beyond the subsidy amount, would become part of their tax assessment and could be regularly deducted from their paycheck. The principal problem with this approach is that prospective eligibility is administratively difficult and does not address income fluctuations. Even for those without income fluctuations, this year's phaseout could not be calculated until last year's return had been filed, which is usually four months into the next year.

which may be difficult and costly. The uninsured would benefit from having an alternative that provided the premium advantages and efficiencies of group coverage. Many of the uninsured might obtain group coverage if more employers were encouraged to offer health insurance, or if new purchasing arrangements were developed. In addition, existing purchasing groups, such as state and federal employee benefit pools and public programs (Medicare, Medicaid, and CHIP) could be modified to offer coverage to those without access to other forms of group insurance.

The significant share of the uninsured with large health risks finds it most difficult to rely on the individual market (Simantov, Schoen, and Bruegman, 2000). Programs based on individual tax credits, for example, would generally provide the same amount of money to all qualifying beneficiaries of the same income and family size, regardless of age or health status. This means that, even with subsidies, higher-risk people may not be able to afford coverage.[4] For example, data from individual markets indicate that coverage for a healthy adult age 60 may be four times more expensive than coverage for a healthy 25-year-old (Simantov, Schoen, and Bruegman, 2000).

One way to address this problem is to impose community-rating or age-band limits. This would bring down average premiums for high-risk people, at least in the short term. Unfortunately, it may do so at the cost of driving many low-risk people out of the insurance pool, unless efforts are made to keep them in. In the long run, it may lead to disintegration of the health insurance market as insurance plans fail to attract enough healthy people to stay in business.

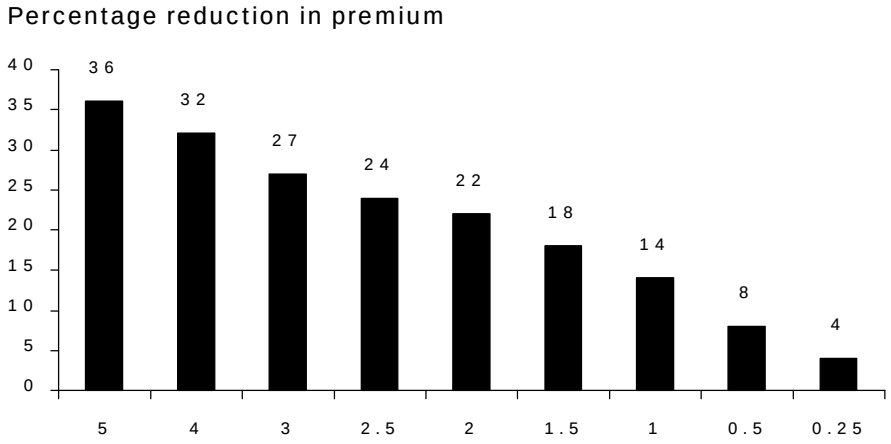
This problem of adverse selection is likely to be even more serious if coverage within a voluntary pool (such as FEHBP, CHIP, or a private purchasing pool) is community rated, but exists within a non-community-rated insurance market. Only higher risk people will join the community-rated pool. To sustain the community rates, systems of reinsurance or explicit anti-selection subsidies could help sustain these groups.

Public reinsurance can effectively address problems of selection in a group purchasing venue, and simultaneously lower premiums for all participants and, perhaps, attract insurers to participate in the pool. Figure 7 illustrates how a public reinsurance pool for the highest-cost cases could reduce premiums overall. Removing as few as 1 percent of highest-cost cases from the pool would reduce premium costs by 14 percent (Actuarial Research Corporation, 2000). Of course, these costs would still have to be borne by the public reinsurance provider.

[4] As noted above, one way to address this problem (to some extent) would be to have incentives cover a fixed percentage of premiums.

Figure 7

Effect of Reinsurance on Premiums



Source: Based on tabulations by Actuarial Research Corporation, September 2000.

There are other ways to reduce selection in new purchasing pools and programs. All qualifying beneficiaries could be required to purchase coverage through pools. Healthier people might still reject coverage altogether, especially if premium assistance did not cover the full cost of care, but they would not be able to select against the pool by remaining outside the community-rated purchasing venue. Employer pools reduce selection partly by limiting enrollment to specific periods. Many purchasing venue proposals also incorporate this feature. However, if the timing of enrollment were limited, exceptions for people who had lost health insurance coverage would have to be made, consistent with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Finally, special incentive arrangements could be targeted at high-risk groups, such as those over 55 (Short, Shea, and Powell, 2000).

Fourth, people gain and lose coverage throughout the year. Many uninsured people spend long periods without health insurance. This group will have ample time to learn about the availability of new coverage options and can sensibly be served by programs that measure eligibility annually. However many people who are uninsured at any given time become insured shortly thereafter. It is important to serve this population, since many of the medical and financial consequences of being uninsured may occur even during short periods without coverage. At the same time, this population is particularly difficult to serve, since its members have less time and incentive to learn about programs and need to join and leave programs at different points during the year.

Prorated eligibility determinations throughout the year would be particularly useful for low-income workers who lose jobs that offered health insurance coverage. Targeting groups in transition, such as individuals moving from one job to another, who expect to be uninsured only for a short period, may also have advantages.

Fifth, all programs that target coverage at subsets of the population must have some phase-out mechanism. But phaseouts can have perverse effects. For example, premium assistance targeted to low-income families may provide these families with an incentive to keep their incomes below the phase-out range. As the incomes of these families increased, they would risk losing their access to low cost coverage. If a program targets firms below a fixed-size cutoff, businesses may face a disincentive to grow larger. If a program targets low-wage firms, firms may be deterred from hiring higher-wage workers. The magnitude of these phase-out effects depends on the generosity of the initial incentive, the steepness of the phaseout, and the extent to which the phaseout coincides with other existing program phaseouts. For example, if the phase-out range of a new health insurance incentives or credits coincided with the phase-out range of the earned income tax credit, families whose incomes fell within both phase-out ranges would face an enormous implicit marginal tax.

Problems of Incremental Coverage

Universal coverage would readily solve all of the problems described above, as would a health insurance system that enrolled everyone automatically and then determined appropriate financing sources. If all Americans were automatically enrolled in a fully paid insurance plan, as all elderly Americans are enrolled in Medicare A, coverage would be universal, everyone, including those at high risk, would have a venue in which to purchase coverage, work transitions would no longer place people at risk of financial or health catastrophes, and the disincentives caused by program phaseouts would be eliminated.[5] Alternatively, a system of enforced coverage mandates, whether employer or individual mandates, would also go a long way toward eliminating these problems. However, in the absence of universal coverage and mandate proposals, policy makers need to consider incremental options that do not undermine existing coverage.[6]

Two general types of incremental health insurance reform are possible: expansions of existing public programs, and expansions of coverage in other ways. The latter category includes programs that provide incentives to individuals or to employers, and those that create new purchasing arrangements for individuals or employers. Public expansions and other options can also be combined in various ways, or targeted at particular groups.

[5] Or at least transferred to the tax system.

[6] At the state level, employer mandates are limited by ERISA legislation. However, under certain circumstances, play-or-pay strategies may be permissible (Butler, 2000).

By definition, the funding for incremental expansions, including those discussed here, will not be large enough to cover all those currently uninsured. Thus, when examining new incremental programs, it is important to consider how many people will gain coverage through them. If expansions attract individuals who previously held private coverage (or who would otherwise take up private coverage), they will, at a given cost, cover fewer of the uninsured. The importance of this concern depends on the nature, cost, and quality of the subsidized program. It would be inefficient to encourage employees to drop low-cost, high-quality unsubsidized group coverage in favor of high-cost, subsidized, individual coverage. But improving the coverage of those who are underinsured or currently face excessively high out-of-pocket costs is also a worthwhile policy goal. Thus, it may be desirable, albeit more costly, to allow employees to drop poor quality group coverage with high employee premium shares in favor of better public coverage that facilitates access to care.

Many incremental expansion proposals contain provisions that seek to target coverage only to those previously uninsured.[7] For example, some proposals limit eligibility to those who are not eligible for an employer-sponsored plan, or to those who have not held employer-sponsored coverage in some preceding period (usually three to six months). These so-called "firewall" provisions raise three concerns. First, they favor employees and employers who failed to act in desirable ways (by failing to offer or take up coverage) and discriminate against those who acted in desirable ways. Second, they make it more difficult to provide coverage for some groups of the uninsured, particularly those who have recently lost a job that offered coverage and those who cannot afford the employee share of the coverage they are offered. Finally, they raise issues of enforceability and administrative costs. In particular, firewall provisions can prevent people from dropping coverage and immediately signing up to receive alternative coverage, but they cannot encourage people to take up new private coverage as quickly as possible. They may also throw up so many administrative hurdles that the targeting provisions they participation or retention rates among those who truly do qualify.

All incremental health insurance expansions present targeting problems, which are likely to be more severe as the income of the group served increases, and as the new coverage program overlaps with existing private coverage. The greater the likelihood that public expansions and existing private coverage will overlap, the greater the concern that expansions may not result in a net increase in coverage.Targeting is an important consideration, but it should not be the only criterion on which to judge a program. No

[7] Note that similar provisions exist in some semi-universal programs, such as the Medicare as Secondary Payer provisions of the Medicare program (Glied and Stabile, forthcoming).

program can be perfectly targeted, and many existing health insurance incentive programs (particularly the tax exemptions for employer-sponsored insurance) are very poorly targeted (Glied, 1999). Programs that provide benefits to many people who were previously insured may, nonetheless, improve the well-being of low-income people. In particular, they can help people who change jobs and currently experience periods without insurance to retain complete and continuous coverage and may improve the quality of health insurance and enhance financial security.

Criteria for Evaluating Expansion Options

Any proposal for incremental coverage will have to address the problems described above. The problems are linked in a way that makes it impossible to solve them all at once. Increasing participation comes at the price of reducing targeting. Allowing people to take up coverage throughout the year makes it easier to accommodate transitions, but raises the risk of adverse selection. Thus, proposals must make trade-offs among goals.

Different people will certainly prioritize these goals differently. However, in general, several considerations probably dominate. First, participation is a critical goal. A well-designed program that fails to reduce the number uninsured is of little value. Second, wherever possible, people in similar situations should be treated in similar ways. This standard of equity is both compelling in principle and efficient in practice. Programs that treat similar people differently are likely to lead to distortions of labor markets as well as health insurance markets. Third, programs should provide the maximum possible benefit to those in need. Dollars should be targeted to the uninsured, underinsured, and those experiencing financial hardship as a consequence of the cost of health coverage. Mitigating specific issues such as timing, targeting, crowd-out, and selection should be thought of as means to these ends, not ends in themselves.

SECTION III. NEW COVERAGE EXPANSION OPTIONS

The next section describes a series of policy options and assesses them in light of the principles described above. These options fall into four categories: expansions of public coverage, individual purchase incentives, expansions of employer-based programs, and proposals that focus on specific groups. The discussion draws on the 10 expert background papers commissioned by the Task Force and describes both general approaches and the specific options examined in these papers. The papers themselves describe in detail how each option might best be implemented. Table 2 provides an overview of the provisions of each of these detailed options.

Table 2

Building New Bases to Expand Coverage to Working Adults, Early Retirees, and the Unemployed—
Option Papers Commissioned by The Commonwealth Fund Task Force on the Future of Health Insurance

PAPER TITLE AND AUTHOR(S)	DESCRIPTION
Individual Incentives	
A Health Insurance Tax Credit for Uninsured Workers Larry Zelenak	A key issue for uninsured adult workers is the cost of insurance. This paper 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.
Public Subsidies for Required Employee Contributions Toward Employer-Sponsored Insurance Mark Merlis	Some uninsured workers have access to employer group coverage but find the cost of their premium shares unaffordable. This paper 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.
Markets for Individual Health Insurance: Can We Make Them Work with Incentives to Purchase Insurance? Katherine Swartz	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 discusses how individual insurance markets might best be designed in view of this trade-off.
Building New Bases for Expanded Coverage: Public Program and Employer-Based Options	
Buying into Public Coverage: Expanding Access by Permitting Families to Use Tax Credits to Buy into Medicaid or CHIP Programs Alan Weil	Medicaid and CHIP offer administrative structures and plan arrangements with the capacity to enroll individuals and families. This proposal would permit, but not require, tax-credit recipients to use their credits to buy into Medicaid or CHIP.
Private Purchasing Pools to Harness Individual Tax Credits for Consumers Richard E. Curtis, Edward Neuschler, and Rafe Foreland	Combining small employers into groups offers the potential of improved benefits, plan choice, and/or reduced premium costs. This proposal would establish 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.

Continued on next page

PAPER TITLE AND AUTHOR(S)	DESCRIPTION
Building New Bases for Expanded Coverage: Public Program and Employer-Based Options (continued)	
Increasing Health Insurance Coverage Through an Extended Federal Employees Health Benefits Program Beth C. Fuchs	The FEHBP has often been proposed as a possible base to build on for group coverage. This paper 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.
Allowing Small Businesses and the Self-Employed to Buy Health Care Coverage Through Public Programs 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 proposal would allow the self-employed and those in small businesses to buy coverage through these public plans, and would provide premium assistance to make it easier for them to do so.
A Federal Tax Credit to Encourage Employers to Offer Health Coverage Jack A. Meyer and Elliot K. Wicks	Employers who do not currently offer health benefits to their employees cite costs as the primary concern. This paper examines the potential of offering tax credits (or other financial incentives) to employers of low-wage workers to induce them to offer coverage.
Adults Approaching the Age of Medicare and the Unemployed	
A Workable Solution for the Pre-Medicare Population Pamela Farley Short, Dennis G. Shea, and M. Paige Powell	Adults nearing but not yet eligible for Medicare are at high risk of being uninsured, especially if they are in poor health. This paper 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.
Transitional Subsidies for Health Insurance Coverage Jonathan Gruber	The unemployed and those switching jobs often lose coverage due to an inability to pay premiums. The paper suggests ways that the existing COBRA program could be enhanced to help avoid these uninsured spells.

Expanding Existing Public Programs

To date, most attempts to increase coverage have focused on developing and expanding public programs. During the 1980s, states, encouraged by the federal government, expanded their Medicaid programs to cover more children and pregnant women. Several states went beyond federal mandates and both expanded Medicaid and developed new state programs for the low-income uninsured. In the 1990s, a new federal-state program, the State Children's Health Insurance Program (CHIP), extended coverage to still more children. One option for expanding coverage is to build on these existing programs. The Kaiser Commission on Medicaid and the Uninsured has considered a range of options for expanding existing public programs. These are summarized for the Task Force in a paper by Diane Rowland, Christina Chang, Rachel Garfield, and Barbara Lyons (Rowland et al., 2000).

Most proposed expansions of these programs would follow existing models. The federal government would offer states matching funds if they expanded these programs to new populations. Expansions of Medicaid and CHIP are likely to address the need for coverage among the lowest-income uninsured, with incomes below 125 percent of the poverty line. Many families in this group are likely to have held Medicaid or CHIP coverage in the past, so they may be familiar with the operation of the programs and may have ties to providers who participate in them. This will be particularly true for programs that extend Medicaid or CHIP coverage to parents of participating children. Such programs may also increase the take-up rate among eligible children by allowing families to address the insurance needs of all their members with one application, as most families with employer-sponsored insurance already do (Thorpe and Florence, 1999).

Public programs rely on existing state administrative capacity to determine eligibility and process applications. These state mechanisms are adept at adjusting to frequent changes in income and can process eligibility on a month-to-month basis. For those who participate in other means-tested state programs (primarily TANF and Food Stamps), eligibility and enrollment for expanded public health insurance programs can be handled as part of an existing process. Several states have adopted expedited application and eligibility processing systems, including systems that operate by mail or telephone. State programs offer a ready-made venue for the purchase of coverage and already monitor the quality of coverage offered through participating managed care plans. States have already developed methods of addressing the needs of higher risk participants, either through carve-outs, risk-adjustment methods, or exemptions from managed care programs.

State administration of expanded public insurance programs also has costs, however. Working people may view public programs either as a welcome health

insurance option or more negatively, especially if application forms are complex and participation requires interactions with the welfare office. In the past there have been concerns that a "stigma" associated with public programs deterred participation, but mounting evidence suggests that this effect is quite small (Remler, Rachlin, and Glied, 2000). Those not already participating in another public program cannot purchase new public coverage in the context of any other transaction, and signing them up is far from automatic. Thus it is not surprising that take-up rates for Medicaid have been disappointingly low among those who were not also eligible for AFDC and among children newly eligible for CHIP (Currie and Gruber, 1996). These barriers are less likely to be important for those with health problems, who may be on the lookout for coverage, or who may use hospitals and other institutions that can provide information and enrollment assistance. Renaming public programs, changing their eligibility certification procedures, and linking them with private plans may substantially reduce any stigma associated with them. However, new programs will need extensive marketing efforts to attract applications from healthy people who might otherwise be unaware of them.

In summary, expanded public programs can readily address cost, venue, and timing problems in extending coverage, but they do not make coverage automatic. They must be combined with aggressive public marketing and outreach efforts. They are likely to be most effective in enrolling very-low-income populations who already have experience with needs-tested programs and people with higher expected health care costs who are actively seeking coverage.

Looking Beyond Current Public Coverage: Other Options

Of all the methods for providing expanded voluntary, non-universal coverage, public programs would most effectively target the lowest-income uninsured. This series of papers commissioned by the Task Force looked beyond expansions of Medicaid or CHIP however, to explore options that target those with slightly higher incomes, and they examine potential sources of affordable coverage for the working-age population without ready access to group coverage through larger employers. These options include incentives to individuals to purchase coverage or employers to offer coverage and new venues for individual and employer purchase. We summarize these options here.

Incentives and Premium Assistance to Individuals

Public programs provide insurance directly, but another way to expand coverage is to provide financing, in the form of financial incentives, to individuals so they can purchase their own health insurance. In some proposals of this type, incentives would be combined with additional administrative mechanisms, such as new venues for insurance purchase.

Premium Assistance Incentives

Incentive programs generally offer more extensive premium assistance to lower-income people and phase out above some income level. In the discussion that follows, we consider a fairly typical proposal that offers a maximum incentive in the form of a refundable tax credit (or voucher) to the population below 200 percent of the poverty line, with a phase-out range up to about 300 percent of the poverty line. The incentive amount would be greater for family than for individual coverage. Larry Zelenak's paper for the Task Force describes how an individual incentive program could operate through the tax system.

Table 3
Basic Health Insurance Tax Credit (HITC) Framework
for Option Papers

- *Who is eligible?* An individual or family with modified adjusted gross income (MAGI) at or below 200 percent of the federal poverty level (FPL) is eligible to receive a full tax credit with a partial credit up to 300 percent of poverty.
- *How large is it?* The maximum tax credit is $2,000 or $4,000 for individuals and families, respectively. The credit is then reduced by $150 for every $1,000 of MAGI exceeding 200 percent of the FPL.
- *How is it distributed?* The IRS determines eligibility at the start of the year and issues a percentage of the tax credit at regular intervals over the year. Reconciliation of the difference between the amount of advance payments and the actual amount of the credit occurs at year end.
- *What will the tax credit be used for?* Tax credits may be used to purchase health insurance. They are adjusted to reflect the age/sex ratings commonly applied to non-group premiums.

The amount of the premium purchase incentive may be either fixed (lump sum) or defined as a percentage of the insured's premium. The advantage of a lump-sum incentive is that it can be designed to cover the full cost of (inexpensive) insurance for at least some uninsured people. Zelenak discusses how a lump-sum tax credit could be age and sex rated, bringing the size of the incentive more in line with the costs of coverage for many people. An incentive defined as a percentage of premium would not cover the full cost of care for anyone.

Unfortunately, it would be nearly impossible to administer a system with a lump-sum premium assistance or tax credits that varied depending on individual health status and on the costs of coverage in a geographic area. In most states individual health insurance is not community rated, and unless the credits or purchase incentives are pegged to health status, they will fall far short of individual premium costs for those in poor health. If set at a national average, in high-cost states, a lump-sum assistance or incentives

would cover only a portion of the cost of insurance even for most healthy, qualifying beneficiaries. For example, health insurance costs in New England States are about 35 percent higher than those in Mountain States (Actuarial Research Corporation tabulations of the Medical Expenditure Panel Survey).

Such insurance purchase incentives can be delivered through tax credits or vouchers. Tax credit programs, such as the Zelenak proposal, would operate through the existing administrative mechanisms of the Internal Revenue Service. A model for their operation is the Earned Income Tax Credit (EITC) for low-income workers who file tax returns. Voucher programs would be operated by the states, with a federal match or incentive. However, all states would need to develop administrative mechanisms that met federal standards to determine eligibility.

The greatest weakness and the greatest strength of the tax credit approach is that it relies on the tax system. The tax system's weakness is timing.[8] The tax system operates retrospectively, assessing income once, at the end of a calendar year. However, insurance operates prospectively. This means that uninsured people would have to pay for coverage before they received the government premium assistance. Most uninsured people do not have the cash on hand to make payments, even if they are assured of reimbursement.

The tax system could make advance payments to those eligible for a health insurance tax credit.[9] Advance payment is administratively complex for the IRS because income determinations must be made and funds must flow before tax returns are filed. Furthermore, if advance payments are made, the IRS must reconcile total payments at the end of the year. If a family is eligible for a smaller credit (purchase voucher) than initially indicated, the family must repay the excess. Fear of such repayments could deter people from accepting the incentive. Concerns about the cost of performing such reconciliations, especially for small sums of money, and the potential for fraud if reconciliations are not completed, might also undermine political support.

Zelenak recommends paying out a smaller share (for example, 60%) of the purchase incentive as an advance payment. Uninsured people would still have to pay something before they received the credit or premium assistance, but reconciliation would be substantially easier. In addition, insurers might respond to the market created by the

[8] For those who are not required to file a form 1040 because their incomes are too low, a tax-credit–based system would require that they filed a tax return. This problem is mitigated by the fact that most of those who become eligible for the new credit would also be eligible for the earned income tax credit and would benefit from filing a return.

[9] A similar provision, albeit rarely used, also exists for the earned income tax credit.

new incentive program by offering coverage packaged with loans in anticipation of the final incentive payments, just as loans are now offered in anticipation of tax refunds.

The tax system would deliver retrospective credits or payments to tax filers nearly automatically. Tax filers would only need to show proof that they purchased insurance during the previous year to receive a tax credit. A system of advance payment vouchers would be somewhat less automatic. Zelenak recommends that employers be required to inform workers about the advance payment program, just as they currently must inform workers about the EITC advance payment option. Similarly, employers could be required to deduct insurance premiums from pay and remit them to insurers.[10]

Voucher programs do not benefit from the automatic elements of tax filing. They also require the establishment of a new administrative structure. However, these programs do have much more flexibility in setting the amount of the voucher, determining income, and making timely payments. Furthermore, states could adjust the amount of payment under a voucher program to track state health care costs. Voucher programs could provide incentives to non-filers through a different administrative mechanism. They could also adjust payments for monthly changes in income, and make non-reconciled advance payments, depending on federal rules.

In summary, incentives covering a portion of the cost of individual coverage can help uninsured people who can afford to pay something to purchase coverage. If the incentive operates through the tax system, the problem of reconciling payments must be addressed. Purchase incentives would not in themselves provide people with a place to buy coverage, nor would they ensure that affordable coverage would be available to everyone. They would not automatically address the needs of high-risk people or those in high-cost areas. It may be difficult to design an incentive program to accommodate transitions in insurance coverage. These problems can be addressed, in part, through group purchasing options that could accompany credits or vouchers.

Offering a Venue for Purchase: Individual Market or Group Coverage Options

Individual premium assistance programs can be freestanding or they can operate as part of system for purchasing insurance. The simplest system would allow qualifying beneficiaries to use their credits or vouchers in the existing individual insurance market. Rules that govern the individual market, such as HIPAA, would continue to apply, as would any market rules implemented in a beneficiary's state.

[10] States could be given the option to establish premium clearinghouses that could lessen the administrative burden on employers of remitting these payments.

The health insurance credit of 1991–92 that was later repealed used this bare-bones structure (General Accounting Office, 1994), which has several advantages. In the case of a tax credit, it limits the responsibilities of the IRS, so that it must only carry out determinations of income eligibility. It also permits the market full rein to adjust to the needs of insurance beneficiaries. It is not at all clear what type of coverage would be most appropriate for qualifying beneficiaries, and the heterogeneity of this population suggests that different types of coverage might be best for different subgroups. Some might prefer managed care coverage; others might want catastrophic protection. The market could also respond to the credit by developing packages that combined insurance with loans against future tax credits, as Zelenak suggests. A market approach may also encourage aggressive private-sector selling of insurance products. In this context, insurance agents seeking credit beneficiaries could perform a very useful information function, which could increase take-up rates.

However, an unregulated insurance market also carries risks. As past experience with health insurance credits shows, some of the products sold in the private non-group market will have little real value (General Accounting Office, 1994). The fact that many beneficiaries will be fully financed by public premium assistance and will not be paying their own cash for the new products only increases the likelihood of fraud. Some proposals would require that all products paid for with credits have an actuarial value equal to or exceeding some minimum. However such a provision would require states (or some federal agency) to make official determinations of actuarial value.

Regulating the Individual Insurance Market

An alternative would be to provide individual purchase incentives or subsidies for use in a more stringently regulated individual insurance market. Several states now impose substantive regulations on the sale of individual insurance. They often limit the premiums that can be charged to people who are in poor health (through rate bands or community rating). They may also require that insurers offer predetermined benefit packages. Specifying benefit packages reduces concerns about the quality of the product that is sold and can make comparison shopping easier. It may also, however, reduce the range of insurance products for sale. It may also reduce the incentive for insurers to aggressively market their products.

In her paper for The Commonwealth Fund Task Force, Kathy Swartz describes the effects of regulating the individual insurance market. She points out that effect of regulating that market involves a trade-off between the premiums offered to high-risk purchasers and the premium offered to lower-risk purchasers. She recommends that proposals incorporate a separate system for subsidizing the premiums of high-risk people.

She considers three types of systems—risk adjustment, reinsurance, and ceding of claims. Any of these would improve the functioning of the individual health insurance market and spread the cost of high-risk people across a broad pool.

Coverage purchased in the individual market is about 40 percent more expensive than comparable coverage purchased through a large group (Congressional Research Service, 1988). The higher cost of non-group coverage is attributable to several factors. First, those who choose to buy non-group coverage are, on average, of higher risk. Second, insurance agent commissions, marketing costs, and underwriting costs operate on a per-sale basis and so are proportionally much lower for group coverage. Third, group purchasers are better able to search for the best-quality products at the best prices than individuals are, and they are likely to have greater leverage when negotiating a contract. Finally, turnover is much higher in the individual and small-group market than in the group market, so administrative expenses are incurred more often.

Regulation of the individual insurance market is unlikely to have much impact on these costs, but more formal institutional arrangements might address these problems.

Private Purchasing Pools

One option is to develop one (or more) new private purchasing pools in each state where all qualifying credit (or premium assistance) beneficiaries would purchase coverage. These purchasing pools would offer one-stop shopping for health insurance. They could limit the number of participating insurers, negotiate terms with insurers, provide comparative information on the cost and quality of plans, assist in enrolling individuals into plans, collect and process premiums, and offer customer service to purchasers. By offering these services, private purchasing pools might reduce some of the costs associated with the individual market.

Existing purchasing pools have had difficulty attracting and retaining subscribers. Without a critical mass of subscribers, the pools face substantial selection problems and cannot attain optimal scale. However, if individuals could use incentives to purchase insurance through pools, the pools could be more viable and, in turn, could improve the way incentives function.

In their paper for The Commonwealth Fund Task Force, Richard Curtis, Ed Neuschler, and Rafe Forland describe a system of purchasing pools that would operate in conjunction with the tax credit program described by Zelenak.

They recommend that the federal government fund the development of private purchasing pools in each state. Multiple pools could operate in each state, but they would all have to meet federal criteria and the number of federal start-up grants would be limited in each state, according to the numbers of potential tax-credit beneficiaries. In order to mitigate adverse selection against the pools, and to give the pools enough buying power to operate effectively, they recommend that all credit beneficiaries be required to purchase coverage through the pools.

These pools would have the power to contract with a limited number of insurance plans. They would be required (in general) to offer at least three different health plans with different benefit packages. At least one coverage option would cost no more than the maximum tax-credit amount. The plans would offer coverage to subscribers, charging age-rated (but not health-rated) premiums to all full-credit beneficiaries. Coverage for partial-credit beneficiaries could be partially health rated.

Pools could also be used in conjunction with other public programs such as CHIP, making it possible for entire families to obtain coverage through the same purchasing arrangements and participate in the same plans. Finally, pools could also include small-employer groups (as Curtis, Neuschler, and Forland suggest). This possibility is discussed below under the section entitled Building on the Employer Base.

Building on Public Programs

An alternative direction would be to make use of purchasing arrangements that already exist. One option would be to allow credit or voucher beneficiaries to use these payments to purchase coverage through state Medicaid or CHIP programs. This would be analogous to existing state programs that permit individuals to buy into Medicaid or CHIP with sliding-scale premiums based on income (see, for example, Call et al., 1997).

Existing public programs offer a well-developed administrative infrastructure. Medicaid and CHIP programs now contract with private managed care plans to deliver health care services. They already regulate plans, educate consumers, and facilitate plan enrollment. In addition, they have used their substantial bargaining power to obtain good rates from insurers, sometimes by making use of lower-cost networks of providers. These functions may enable them to lower costs and offer more complete coverage to qualifying beneficiaries than those available in the non-group market.

A further advantage of using existing public programs is that they could facilitate the process of administering advance-payment tax credits. These state programs already perform income eligibility determination in a way that satisfies the Federal government.

They could use this apparatus to assess income eligibility for credit beneficiaries, eliminating the need for a year-end reconciliation.

Alan Weil has prepared a paper for The Commonwealth Fund Task Force that describes how individual qualifying tax-credit beneficiaries could participate in the CHIP or Medicaid programs. Low-income families are likely to be familiar with CHIP and Medicaid programs and a new program could capitalize on the extensive marketing that has already been carried out to promote recent expansions to children.

A key feature of Weil's plan is that states would take over the initial income eligibility–determination functions of the tax credit program for those who chose to use the CHIP (or Medicaid) plan. Once families chose to join CHIP, the state, rather than the family, would claim the federal tax credit. Families would not risk having to repay excess tax-credits as a consequence of end-of-year reconciliation. State income determination would also make it easier for families that lose other coverage in mid-year to participate in the tax-credit program.

Just as families often move between being uninsured and private coverage, they also move between being uninsured and public coverage. Furthermore, an estimated 34 percent of potential qualifying beneficiaries have children who are eligible for either Medicaid or CHIP. By using their incentive to buy Medicaid or CHIP plans, these families can ensure that their entire family has the same type of coverage, and that this coverage is maintained if their eligibility for traditional public coverage changes. Furthermore, if the program is properly designed, all members of a family can make health plan decisions at the same time, reducing individual administrative costs. If incentives to purchase insurance were offered, and public programs were not expanded at the same time, this feature would be essential if the program were to be useful to the very-low-income population.

Using Public Employee Programs as a Base

In most states, Federal employees and state public employees already constitute large insurance groups. One possibility would be to permit new qualifying beneficiaries to buy into these existing arrangements. Beth Fuchs's paper for The Commonwealth Fund Task Force describes how the Federal Employees Health Benefits Program (FEHBP)—the plan that serves Congress and 9 million other federal employees and dependents in all states—could be used to provide coverage to new qualifying beneficiaries. The issues described in Fuchs's paper are similar to those that might be involved in opening a state employee's plan to qualifying beneficiaries.

FEHBP offers its members a choice of plans, including a fee-for-service option. FEHBP has been a very effective purchaser of care, selecting and negotiating with plans and offering a venue for making comparisons among plans.

Fuchs describes a program that would run in parallel to FEHBP, and would be known as extended FEHBP or E-FEHBP. E-FEHBP would accommodate beneficiaries qualifying for premium assistance, while protecting FEHBP. All plans that participate in FEHBP would be required to participate in E-FEHBP, but could price their plans at a new community rate that reflected the costs of the newly enrolled population.

In order to avoid adverse selection, high-risk qualifying beneficiaries who signed up for E-FEHBP would be diverted to a separately funded reinsurance pool. Such a pool could substantially reduce premium costs. Removing some of the selection risk, would make it easier for plans to participate in E-FEHBP, and to remain in FEHBP as well. Overall, this option would give qualifying beneficiaries coverage at much lower cost and offer them a much greater choice of high-quality plans, at least in some markets, than they would otherwise obtain in the non-group market.

It is important to recognize, however, that several of the important advantages of FEHBP for federal workers will not naturally accrue to this new population. Qualifying beneficiaries would be required to seek out E-FEHBP, while federal employees are enrolled automatically through work; qualifying beneficiaries would also have to make payments into E-FEHBP, while FEHBP members have payments automatically deducted from their paychecks. Agencies that employ federal workers perform these administrative functions for their own employees—they would not be available to perform these functions for qualifying beneficiaries.

In areas where FEHBP already has a substantial presence (particularly around Washington, D.C.), the existing structures that enroll federal employees might be made accessible to qualifying beneficiaries enrolling in E-FEHBP, and the marketing efforts of existing FEHBP plans easily could be expanded to include qualifying beneficiaries. However, in most areas of the country, the number of new qualifying beneficiaries is likely to substantially exceed the number of current FEHBP participants. New administrative structures, perhaps arranged through states, might be needed to arrange coverage in these areas. Marketing might also have to be undertaken as a separate function.

Fuchs also suggests that E-FEHBP be opened to certain small-employer groups. This possibility is discussed below in the discussion of options that build on an employer base and administrative systems for coverage.

Individual Incentives Summary

Individual incentives operating through the tax system can target new funds to help low-income people buy coverage through the tax system, an existing and familiar administrative structure. Options that relied only on individual purchase incentives would leave beneficiaries dependent on the individual insurance market. Faced with a large new group of potential buyers, the individual market may respond in innovative ways and reach out to enroll credit beneficiaries. The individual market is, however, likely to remain a costly place for people to buy coverage. Without further regulatory interventions, incentives will not be sufficient to pay for insurance for high-risk people in this market. Conversely, some low-risk people may use the funds to buy products of little value.

New purchasing mechanisms for using individual incentives could reduce administrative costs, at least slightly. They may also make it possible to ensure that high-risk uninsured people (qualifying beneficiaries) can afford coverage. Finally, they offer those who often change jobs an efficient way to purchase coverage. These benefits carry costs, however. To avoid adverse selection against these new purchasing mechanisms, most proposals mandate that incentives be used exclusively in these venues, even though some beneficiaries might prefer individual coverage. While new venues may offer many plan choices, the range of available plan characteristics is likely to be more limited than in the individual market.

Incentive programs tied to individuals, whether or not they are to be used in new purchasing venues, must also address a common set of problems. Incentives administered through the tax system must be reconciled at year end, making them less useful to people whose incomes or insurance status fluctuate during the year. Individual premium assistance incentives cannot be automatic—individuals must apply for them and have their eligibility determined, choose plans, and maintain payments. Incentive programs rely on extensive marketing to convince people to participate. Finally, if incentives are to be tied to the individual market, they may undermine, at least at the margins, the existing system of employer-sponsored insurance. If faced with an exodus of low-income to new incentive programs, some employers are likely to stop offering (or not to begin offering) health insurance.

Options for Building on the Employer-Sponsored Base

Neither the individual market nor new administrative structures address all the problems inherent in providing a venue for delivering new incentives for purchasing insurance. Another way to expand coverage is to couple an incentive program with mandatory or voluntary programs that expand employer-sponsored coverage. Examples of this approach include employer mandates, such as pay-or-play laws that require firms either to offer and

finance coverage or to pay a payroll tax toward coverage in a public program (U.S. Bipartisan Commission on Comprehensive Health Care, 1990). They also include mandates that firms offer (but not finance) coverage (Wilensky, 1987). Employers would then perform all insurance administration functions on behalf of their employees, including plan negotiation and selection and payroll deduction. Larger employers would probably act as insurance groups, while smaller employers would have a strong incentive to participate in a purchasing pool or join an extended FEHBP if such options were available. Employers could also automatically enroll employees in individual premium assistance or public insurance programs, using payroll deductions to handle employee premium payments.

The Task Force has focused on voluntary approaches such as credits or premium assistance that help employees buy coverage offered by their employers, incentives that encourage employers to offer coverage, and new mechanisms to help employers purchase coverage more efficiently.

Approaches that expand employer-based coverage will be primarily useful to the 77 percent of uninsured people who are members of working families. Within this group, employer-based coverage will be most valuable to those who have steady jobs with one employer. Once their employers agree to offer coverage, then enrollment, marketing, and premium payment through payroll deduction become as automatic for these workers as for others with employer-sponsored coverage.

Incentives to Individual Employees

One way to encourage employers to offer insurance would be to permit beneficiaries to use tax credits or incentives (vouchers or state program buy-in premium assistance payments) to buy coverage through their employers. Mark Merlis's report for the Task Force describes how individual tax credits could be used to pay the employee share of employer-offered plans. Such a program would be an adjunct to the individual tax credit described by Zelenak and, possibly, the employer-incentive program describe by Meyer and Wicks. A similar system could be used if a public program were to be expanded and at the same time, incentives were offered to help employees pay the premiums for employer-based plans.

Merlis's proposal uses the same incentive structure as the tax-credit proposal described by Zelenak. Families with incomes below 200 percent of the Federal Poverty level would receive a full premium assistance; the premium purchase incentive would phase out at about 300 percent of the Federal Poverty level. Individuals without access to employer-sponsored coverage could elect to use their credits in the non-group health

insurance market. However, the credits described in the Merlis proposal could also be used to finance the employee share of group insurance premiums.

Merlis's proposed program is intended to shore up the existing employer-sponsored insurance system and also increase take-up of an insurance tax credit, by allowing credit beneficiaries to use the nearly automatic enrollment mechanisms of employer-sponsored insurance. If tax credits could only be used for individual coverage, employer-sponsored insurance would likely erode, especially in firms where many workers would be eligible for credits. Permitting credits to be used to purchase employer-sponsored coverage would encourage many of these tax-credit–eligible workers—and their employers—to remain within the employer-sponsored system. However, if workers could choose between individual and employer coverage, healthy workers who are eligible for substantial individual tax credits may still opt out of employer groups. In order to limit this kind of selection, Merlis would require workers to use their credits toward employer-sponsored insurance, if it were available.

Credits used for employer-sponsored insurance could not exceed the employee's share of premiums. This rule might encourage employers to increase the employee share of premiums. To prevent this, Merlis would only allow the purchase incentive to be used to buy employer-based coverage when the employer contributed at least 70 percent of the premium for single coverage and 50 percent for family coverage. Thus, employer-based programs would be cheaper than a system of incentives for the individual market.[11]

Tax credits for employer-sponsored insurance would be paid in advance, to offset the employee's premium costs each month. Employers would determine the advance payment amount for each eligible employee, based on individual earnings, the type of coverage the employee selected, and the employee contribution associated with that coverage. The employee would request advance payment from the IRS using a form similar to that now used for advance payment of the earned income tax credit. The employer would then deduct the advance payment amount from the Social Security and Medicare tax payments it would otherwise make on behalf of that employee. The employer would report advance payment amounts on the employee's W-2 and 1040 forms. Any over- or underpayment of advance payments would be reconciled as part of the standard income tax filing process.

[11] For a few workers in the tax-credit phase-out range, however, the sum of the credit cost and the tax deduction for employer-sponsored insurance might amount to a larger government payment than would be available under the individual tax credit.

Implementation of an employer-sponsored insurance credit would require some additional reporting beyond that needed for an individual credit. Employers would have to report the total cost of insurance coverage and the employee share, so that the IRS could compute the advance payment amount and ensure that the employer share did not fall below the legislated threshold. This information could also be used to collect information on whether or not an employee had access to employer-sponsored insurance.

The employer-sponsored insurance credit proposed by Merlis provides a way to make tax credits portable—available to those working for an employer as well as those working on their own. However, it offers, on average, less public money to employees of firms that offer employer-sponsored coverage than it does to employees of firms that do not offer such coverage. Although employer-sponsored coverage is typically less costly than non-group coverage, public funds could eventually lead some firms and workers to drop employer-sponsored coverage in favor of non-group coverage. Nonetheless, this approach has substantial merits. It would take advantage of the fact that coverage available through employers is usually cheaper and enrollment is nearly automatic. Furthermore, this step would reduce the degree to which the employer market would disintegrate, compared to a system in which credits could only be used in the individual market. Subsidies for employer-based insurance might even encourage employees in firms that do not now offer insurance to demand such coverage. These people would be very well served by this option.

Premium Assistance for Employers

Another way to encourage employers to offer coverage would be to directly fund health insurance purchased through employers of low-wage employees. Unfortunately, past efforts to encourage employers to offer insurance through premium incentives have not met with great success (Silow-Carroll, 2000). Most of these programs were small and temporary. These efforts may be more successful if they offer larger, permanent incentives to provide coverage. Jack Meyer and Elliot Wicks have prepared a paper for the Task Force that describes such a proposal.

Meyer and Wicks propose that all firms with average wages below $10 an hour become eligible for a tax credit (including the few firms in this category that already offer coverage). The credit would be fixed at about 50 percent of the national average cost of a basic benefit package for firms with average wages of less than $7.00 an hour. The amount of the credit would phase out as wages rose.

The tax credit would be administered by the IRS using standard corporate tax accounting procedures. The credit would be paid in advance quarterly and reconciled at

year end. Participating firms would be required to contribute at least 50 percent of the cost of a basic benefit package. This means that firms receiving the full credit would not have to pay anything toward the cost of coverage. Employers receiving less than full credits would have to pay something.

Premium assistance for employers may encourage them to offer insurance, but employee take-up might still be low if the employee share of premiums is high. Therefore, this option might work best in conjunction with individual tax credits for the employee share of premium, as described above, so that both employers of low-wage workers and the workers themselves would be assisted. Small firms would be required to buy coverage in the small-firm insurance marketplace. In many states, this means that high-risk small firms would find it very costly to obtain coverage. Therefore, it might also be desirable to offer small firms a more regulated venue in which to purchase coverage. Employer incentives could also be accompanied by incentives for employees to take up employer offers. These could include direct incentives to employees, as described in Merlis above.

New Private Mechanisms for Purchase of Health Insurance

Providing new mechanisms to help small firms purchase health insurance, either alone or in conjunction with individual or employer premium assistance, could also expand employer-based coverage. In their report for the Task Force, Curtis, Neuschler, and Forland propose that small firms arrange coverage for their employees through private purchasing groups. They suggest that one or more private pools be formed in each state, primarily to provide a venue through which beneficiaries of individual tax credits could purchase group coverage. They also envision that eligible firms could buy coverage on behalf of their employees through these pools. Low-wage firms with 25 or fewer employees would not be required to contribute to the cost of coverage purchased through the pools, though they could do so if they chose. Low-wage employees could use their individual tax credits to pay their share of the premium. Employees who were not eligible for tax credits would pay their share of premiums themselves.

Curtis, Neuschler, and Forland also propose that firms with 25–50 employees also be permitted to participate in pools, although their employees could not use tax credits to pay for their premiums. This would make it easier for firms that anticipated growth (in size or wages) to participate in the program.

E-FEHBP as a Base for Small Employers

In Beth Fuchs's paper for the Task Force, she proposes that the E-FEHBP program also be opened to firms with 10 or fewer employees, whether or not these

employees are eligible for credits. Employers would be required to contribute 75 percent of the premium cost of the benchmark E-FEHBP plan. At least 75 percent of the employees of these firms who were not covered through another source would have to purchase coverage through E-FEHBP. Employees of qualifying firms could participate in any plan offered through E-FEHBP, and could use any tax credits for which they were eligible to pay the employee share of premiums.

Employers would benefit from both the purchasing venue available through E-FEHBP and its reinsurance pool, which could substantially reduce the costs of coverage for small employers.

Combining Premium Assistance, Incentives and a Public Venue for Employer Purchase

Sara Rosenbaum, Phyllis Borzi, and Vernon Smith describe an alternative approach in their report to The Commonwealth Fund Task Force that combines employer incentives, employee incentives, and a venue for employer purchase. They propose an expanded version of the existing State Children's Health Insurance Program (CHIP) that would be available to small firms, defined as those with 25 or fewer employees.[12]

Small firms would be able to purchase coverage for their employees through the expanded CHIP structure. Benefits and cost-sharing requirements would be the same as those in the existing CHIP program. For families with children eligible for CHIP, this provision would mean that the entire family could now participate in the same health plan, without giving up the benefit and cost-sharing features of CHIP.

All participating firms would be required to contribute toward the cost of coverage, at levels determined by the states based on a choice of three benchmarks. The program would then fund employee (and some employer costs) based on either family income or hourly wages (at state option). For workers earning less than $6 per hour (or whose family income was below 100% of the FPL), a government premium payments would cover the full cost of the employee contribution and 25 percent of the cost of the employer contribution. For workers earning more than $6 an hour, the premium assistance for the employee contribution would phase down and there would be no incentive for the employer contribution.

Premium stabilization funds would ensure that firms could predict coverage costs several years in advance. States would organize an insurance marketplace for participating

[12] The program might be implemented initially using a smaller firm size cutoff (10 workers).

firms (they could administer the insurance themselves or contract with private insurers). Insurance products purchased through this marketplace would be guaranteed against premium increases beyond a preestablished limit, such as the medical care component of the Consumer Price Index (MCPI). If insurance premiums rose faster than the MCPI, the government would pay the additional cost.

The costs of the proposed CHIP program would be split between state and federal governments according to current CHIP rules. This means that if families already enrolled in Medicaid or CHIP switched to the new employer-based program, both the federal and state government would save money.

This program would make it much easier for very small firms to purchase insurance, and would offer both a venue for coverage and premium assistance for those with low wage (or low income) employees. Because the program is built around CHIP, it would be most accessible to families of children who are eligible for CHIP or Medicaid. At the same time, the program might be less appealing to firms that expect to grow beyond the required size limits. For such firms, growth would mean both giving up reduced premium rates and finding a new way to purchase insurance.

Building on the Employer Base: Summary

Proposals to increase the number of people covered by employer-based insurance aim to take advantage of the well-established distribution and financing system on which most privately insured Americans already depend. Expanded employer-based systems could make coverage nearly automatic for the more than three-quarters of uninsured Americans who have a connection to the labor market. Employers can take advantage of administrative economies in purchasing coverage, and have more access to information through employer groups or brokers. As a consequence, employment-based coverage would probably be less costly and of higher quality than coverage in the non-group market.

Even if firms want to offer coverage, the small group market often makes it difficult for them to do so. New mechanisms for the purchase of coverage and a system of employer incentives could encourage more employers to offer insurance. However, allowing firms to use new purchasing venues raises the risk of adverse selection against these venues. Furthermore, it may alienate insurance agents and brokers, who provide services to this group of firms.

Working through employers adds another set of actors to the process of expanding coverage. While employee earnings and the cost of coverage are clearly the most important determinants of whether employers offer coverage, it is not clear that purchase

incentives would induce many employers not currently offering coverage to begin doing so. Firms that do not expect to remain in business long, that have high employee-turnover rates, or that experience cash flow problems may not wish to add coverage even with employee or employer premium assistance or credits.

Similarly, employer incentive and purchasing programs raise a second set of phase-out problems. Few proposals would allow all firms to participate in incentive or purchasing schemes. This means that when firms grow or raise wages they may lose their incentive payments. While most proposals incorporate gradual phaseouts for individual incentives, few describe phaseouts by firm size.

Finally, programs that operate through employment raise issues of targeting. About 36 percent of Americans have family incomes that would qualify them for an individual premium assistance, and also have at least one family member with an offer of employer coverage. However, the difficulty is that 59 percent of the people in this group already have employer coverage. An estimated 54 percent of those who do not take up coverage today would have coverage within a year even without any incentive. We know little about the quality of that coverage or the financial burden it places on low-wage workers. We also do not know the degree to which incentives might help these workers retain coverage within their employer plans. Nonetheless, these statistics suggest that programs that allow people to use premium purchase incentives to pay down their share of employer premiums would be a less well-targeted approach than individual incentives.

Addressing the Needs of Special Populations

Health insurance in the United States is built around several institutional structures, most notably employer-sponsored coverage and the Medicare program. Another way to expand coverage is to focus on the needs of populations who are in transition between these existing institutional structures, or who move in and out of them. The Task Force has focused on two transition populations: those nearing Medicare age (62- to 64-year-olds), and those leaving employer coverage.

There are over 900,000 people ages 62–64 without health insurance. A further 9 percent—or about 500,000 adults—in this age group buy individual non-group coverage, which can be very costly. One way to help this population would be to simply lower the age of eligibility for Medicare, from 65 to 62. Another possibility would be to permit them to buy into Medicare, which is less costly than private non-group insurance (Loprest and Moon, 1999). President Clinton's proposed budget for fiscal year 2001 (U.S. Office of Management and Budget) would permit all Americans ages 62 through 64 and displaced workers ages 55 through 65 to buy into Medicare. In addition, retirees aged 55 and older

whose employer withdrew employer-sponsored retirement health benefits would be able to extend COBRA (Consolidated Omnibus Reconciliation Act of 1985) coverage until they reach age 65. To make these options more affordable, a tax credit equal to 25 percent of the premium of either the Medicare buy-in or COBRA coverage would be available. To make coverage more affordable for this population, we describe below an expanded approach targeted on those nearing the age of Medicare.

A second important group in transition is the unemployed and those moving in and out of the labor force. About 33 percent of those currently uninsured were insured through an employer during the preceding calendar year.[13] Job transitions are not only an important cause of lack of insurance. A substantial body of research suggests that fear of losing coverage reduces job mobility, at considerable economic cost.

The existing COBRA legislation (H.R. 3128, Public Law 99-272) provides workers who leave jobs with an opportunity to keep their health insurance by buying into the group sponsored by their former employer. HIPAA (Health Insurance Portability and Accountability Act of 1996, H.R. 3103, Public Law 104-191) guarantees that workers leaving a job with health insurance will be eligible for new non-group or employer-sponsored coverage. Neither of these laws helps those in transition pay for their coverage. Below, we describe an option to extend current transition coverage and make it more affordable.

The Pre-Medicare Population

One transitional population of importance is the group approaching Medicare eligibility age. In their paper for The Commonwealth Fund Task Force, Pamela Farley Short and Dennis Shea describe a program that would enhance coverage for this population.

The population approaching Medicare age can be divided into two groups, those who could not plausibly purchase coverage for themselves, and those who, on the basis of their earnings during their working years, could if they had the opportunity. Short and Shea propose different financing systems for these two groups.

Short and Shea propose that the government offer individuals and couples with low lifetime earnings a subsidized voucher, or a refundable tax credit.[14] The voucher would be fully portable, and could be used to purchase private non-group coverage,

[13] Tabulation from merged March 1998 and March 1999 Current Population Survey files.

[14] The voucher might also be operationalized simply as the opportunity to buy into Medicare at reduced rates.

employer-sponsored coverage including COBRA/HIPAA, the basic Medicare package, or any of the Medicare+Choice plans (as discussed below). Eligibility for the voucher would be determined based on average income during the previous 40 years. Using earnings history data, the Social Security Administration would make a one-time determination of lifetime earnings for single individuals and married couples. This information would then be passed on to the Health Care Financing Administration (HCFA), who would then compute the amount of the voucher. Those with average, inflation-adjusted, lifetime income below 100 percent of the current Federal Poverty line would be eligible for the full voucher. The voucher would phase out at 200 percent of the current FPL. Making lifetime income the basis for purchase incentives substantially reduces the potential work disincentive (and retirement incentive) effects of a program geared to current income.

For those with incomes above 200 percent of the Federal Poverty Line, Short and Shea propose a dedicated savings program to help pay for health insurance. The savings program could be implemented through either a private or public program, or people could be given a choice. The private savings plan would operate like a modified "Roth" IRA. People could make contributions to it beginning at age 50, and interest on these contributions would not be taxed. Contributions could be withdrawn from the IRA to purchase health insurance, beginning at age 62. After age 65, contributions could be withdrawn for any purpose. Under a public savings plan, people over 50 could choose to supplement the payments they make to the federal government through payroll tax deduction or the income tax system. These additional tax payments would earn a guaranteed rate of tax-free interest. Again, proceeds could be withdrawn beginning at age 62 to buy health insurance coverage. This public option might appeal to those with lower incomes. Finally, participants in either savings program who became disabled (and eligible for SSDI) before age 62 would be allowed to "buy down" the 24-month Medicare waiting period at an actuarially fair rate with distributions from the savings program.

Short and Shea propose that vouchers and tax-favored savings could be used to buy non-group coverage in the private market or employer-based coverage. In addition, these funds, as well as other resources, could be used to buy into Medicare at community rates. The Medicare buy-in would be very valuable for seniors, especially those without access to employer-sponsored coverage.

Older people in poor health are likely to favor buying into Medicare at community rates. This could cause adverse selection, and to address this, Short and Shea would make the value of the insurance voucher higher when used in the Medicare program than when used in the private market. Since the pre-Medicare savings program

already limits adverse selection by encouraging participation long before most people can reasonably predict their health status at age 62, there are no restrictions on the use of accumulated savings.

Eligibility and participation would not depend on employment status, and employers and employees could take advantage of this in several ways. Firms that do not currently offer coverage may begin to do so, with minimal employer contributions since eligible employees could use their pre-Medicare savings or vouchers towards premiums. Employers could also contribute to their employees' pre-Medicare IRAs instead of providing retiree health benefits in the future. Finally, employer administration of pre-Medicare IRAs would make it easy for workers to use their savings accumulations for group premiums, whether or not their employers contributed anything.

By allowing vouchers and savings to be used both to purchase employer-sponsored coverage and to purchase Medicare, this plan offers older Americans seamless transitions between modes of insurance coverage. While they are working, vouchers and savings could pay for employer coverage. When they retire the voucher or savings could be used to buy Medicare coverage that would continue after they turned 65.

Unemployed People

A second group who would benefit from transitional coverage are those who become unemployed. The 1986 COBRA legislation permits workers who lose their jobs (in firms with more than 20 employees) to continue in their employer plans if they pay the full premiums themselves. If health insurance tax credits became available, they could be used to pay for COBRA coverage. Another possibility would be to extend COBRA coverage beyond the present 18 months (29 months for those who are disabled) and allow the incentives to be used for this entire period. However, this might discourage employers from offering coverage to short-term employees. Past experience has shown that workers who choose COBRA coverage have substantially higher health costs than the average worker.

Gruber has written a paper for the Task Force that describes a program that would provide longer-term coverage under COBRA, and would be more affordable for both employees and employers. He proposes that COBRA benefits be available for 36 months, rather than the current maximum of 18. Workers in all firms, not just those with more than 20 employees, would be eligible. Gruber would also require that employees had at least one (possibly two) years of prior tenure before becoming eligible for COBRA. This provision would reduce the extent of adverse selection in the program.

An important problem with COBRA is that workers are suddenly faced with the full cost of health insurance (not just the employee share) at a time when they have lost their jobs and their resources are constrained. Gruber proposes that the government operate a new COBRA-LOAN program that would assist workers during this period. The government would offer loans at favorable (government) interest rates to every COBRA enrollee. Repayment would begin one year after the end of the loan period, and would continue for the duration of the original loan.

Many newly unemployed workers never return to jobs that offer affordable coverage. To address this group, Gruber proposes a loan forgiveness program. Workers whose annual incomes were below the FPL during the year following the loan period would have their entire loan forgiven. Loan forgiveness would phase out at 300 percent of the FPL. In general, loan repayments would always remain below 10 percent of income.

COBRA-LOAN would be administered by a new government entity that would pay employers directly for health insurance premiums incurred by former workers covered by COBRA-LOAN. It would also set schedules for and accept loan repayments. To further assist employers in administering the program, COBRA-LOAN would be coupled with a new tax credit for employers equal to the administrative costs of COBRA and COBRA-LOAN.

Gruber's program is designed to make COBRA more attractive to workers undergoing job transitions. It should make COBRA coverage accessible to low-income workers. It could also be useful for early retirees waiting for Medicare who now face very high premiums in the individual market. Finally, by making COBRA more attractive and requiring a period of prior tenure, COBRA-LOAN should reduce the degree of adverse selection in the COBRA program. Employers are also likely to find this option desirable, because it offers incentives for the administrative costs of COBRA.

Special Populations Summary

Proposals that focus on populations in transition are not designed to develop new institutions. They envision that none will remain with the transitional insurance program for very long. Instead, they offer the uninsured (and those with high insurance costs) better short-term options.

For this reason, enrollment in transitional programs should be as nearly automatic as possible. People who do not expect to participate in a program for long will be unlikely to invest much in learning about the program or applying for it. The existing COBRA program provides workers with information about continuing their current coverage.

While employers are already mandated to provide this information to workers, they have strong disincentives for doing so, because COBRA has administrative costs. By subsidizing these administrative costs, the COBRA-LOAN program may encourage more employers to inform their employees about COBRA.

A new transitional program for the pre-Medicare population will also have to develop mechanisms for informing eligible people. Short and Shea propose making eligibility for the savings program universal and tying it to existing savings and tax vehicles. The use of a lifetime social security income test for the voucher program could also make receipt of vouchers by low-income seniors nearly automatic. However, the voucher and savings program will not make enrollment in health insurance fully automatic. People who do not already purchase coverage will have to decide whether to take up Medicare. Once they decide to do so, however, enrollment should be quite straightforward.

CONCLUSIONS

No single incremental approach is likely to meet the needs of all the uninsured. Nor does any single approach perfectly balance issues of participation, targeting, and equity. Policy makers will always face trade-offs among these goals.

Many of these strategies complement each other. The strategies described above could work together to address the diverse needs and situations of the uninsured. Approaching the uninsured from many angles at once is likely to be more effective than using a single approach in isolation. While our fragmented and heterogeneous health insurance system appears to call for innovations that add rationality and order, a more effective incremental approach may be to add further complexity. The structural gaps and population needs are diverse and a mix-and-match approach may work best. The options described above would likely work best if coupled with each other, as part of a systematic approach to building new bases to cover the uninsured. It is critical, however, that the increased complexity remain at the level of the program and not overwhelm the participant.

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#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.

#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.