



PUBLIC SUBSIDIES FOR REQUIRED EMPLOYEE  
CONTRIBUTIONS TOWARD EMPLOYER-SPONSORED INSURANCE

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## EXECUTIVE SUMMARY

Many low-income workers decline employer-sponsored insurance (ESI), very often because of the high cost of employee premium contributions. The federal government could subsidize employee contributions to ESI through a tax credit, which would be known as ESIC. In this way, employers would continue to contribute to insurance for their workers, and more federal dollars could be used to reach a greater number of low-income workers. The ESIC described here would be part of a broader program of tax credits for low-income workers. An ESIC might also be offered in conjunction with a public program, such as Medicaid or CHIP. In a tax credit program, workers without access to ESI would be able to obtain credits to purchase insurance in the non-group market. Workers with access to ESI would be ineligible for the non-group credit, but would receive the ESIC instead. Such workers should prefer the ESIC to non-group insurance because it is more convenient to obtain coverage through an employer than to shop around in the non-group market, and because Americans tend to prefer employer-based benefits.

Some proposals to subsidize non-group health insurance seek to exclude those with employer offers. Such a provision might be feasible in a short-term program, or one designed to reach only a small proportion of the uninsured, but in the long term, such a policy would be unfair to low-income workers who currently pay their own premiums. In addition, if the non-group credit were available to workers in firms that did not provide ESI, employers would increasingly offer higher wages rather than insurance to attract new workers. This could eventually erode ESI. An ESIC might help to stem the erosion of ESI that could occur if a tax credit were only available in the non-group market.

The ESIC would be available only to workers in firms that pay a specified percentage, say 70 percent, of their workers' premiums. This would prevent employers from responding to the new credit by reducing their own contributions and 'gaming' the system.

The ESIC would be equal to the lesser of a) the worker's share of the ESI premium, or b) an income-based cap. Like the proposed non-group credit, the ESIC could be paid out using an advance payment system, to help workers make payments during the year. Workers receiving the ESIC would usually be better off than those receiving the non-group credit, because employer-sponsored insurance tends to be less expensive than non-group insurance, and because even some ESIC recipients in the

phase-out range would be obliged to pay nothing towards their premiums. It is appropriate that the ESIC retain some advantages in order to encourage people to obtain insurance through work.

Workers eligible for the ESIC would be forbidden from obtaining the non-group credit. However, this rule might be unattractive, both to insurers, who would lose part of the new non-group market, and to employers, who would be forced to make greater contributions to employee premiums, as newly subsidized employees took up insurance.

The most difficult administrative problem would be to ensure that those receiving the non-group credit are not eligible for the ESIC. In the past, similar programs have relied on random checks or an honor system. This proposal incorporates a more formal enforcement provision. Employers would need to report their own—and their employees'—premium contributions and their employees' MAGIs to the IRS on the W-2 form.

Many children, especially those in families below the phase-out range, would probably switch from SCHIP to employer-based plans as their parents gained coverage. In this way, the whole family would be covered by the same plan, which would simplify care-seeking, and might even encourage more parents to take up coverage for their children.

There would be no restrictions on the type of benefit plans for which the ESIC could be used. This is partly because the underlying non-group credit proposal includes no minimum benefit, and because a benefit standard for employer-sponsored insurance would be controversial and difficult to administer. However, the absence of a standard means that some workers with access to the ESIC may then have poorer coverage than would be available to them if they had the non-group tax credit.

The ESIC would expand coverage compared to a non-group tax credit alone, but much of the money would be spent on those already insured. In addition, the ESIC could not completely prevent employers aware of the non-group credit option from dropping the health insurance plan and attracting workers with higher wages instead. The extent to which this happens will depend upon how generous the non-group plans for tax credit recipients turn out to be.

## PUBLIC SUBSIDIES FOR REQUIRED EMPLOYEE CONTRIBUTIONS TOWARD EMPLOYER-SPONSORED INSURANCE

### INTRODUCTION

Many low-income workers decline employer-sponsored insurance. In 1996, 17 percent of uninsured people with incomes below poverty, and 28 percent of those with incomes from 100 to 200 percent of poverty, were workers who had been offered employer-sponsored insurance (ESI), or were the spouses or minor children of such workers.<sup>1</sup> It is likely that many of those who fail to take up available employer coverage are deterred by required employee premium contributions. Average employee contributions for single coverage went from \$8 a month in 1988 to \$35 in 1999; monthly contributions for family coverage went from \$52 to \$145.<sup>2</sup> Many workers must pay even higher amounts; employee contributions have been shown to vary by firm size, industry, geography, and the proportion of workers in the firm who are low-wage.<sup>3</sup>

Take-up of ESI by modest-income families might be increased through some form of public subsidy for required employee contributions. Helping with ESI could be more effective than providing insurance directly through a public program or through tax subsidies for non-group insurance, for at least two reasons. First, employers would cover much of the cost, allowing limited public funds to reach more people. Second, families might be more likely to participate in ESI than to enroll in a public plan or shop for non-group coverage, both because enrollment at the workplace is easier and more convenient, and because most Americans prefer employment-based coverage.<sup>4</sup>

ESI assistance could be furnished in a variety of ways:

- Through the tax system, in the form of a new credit or deduction, or by excluding the employee share of premiums from taxable income in the same way that employer contributions are now excluded.<sup>5</sup>
- As a component of a broader public program to reach the uninsured. For example, many states already provide ESI assistance to people meeting the eligibility standards for Medicaid, and a few do so under state child health insurance (SCHIP) or other state programs. (Current premium assistance activities in state programs are described in appendix A).
- As a freestanding initiative.

It seems unlikely that Congress or the states would adopt an ESI subsidy without taking measures to expand coverage for people at the same income level without access to ESI. This paper assumes that ESI assistance would be part of a broader program. Many of the issues in designing an ESI subsidy depend on the nature of the non-ESI program to which it is attached; for example, a subsidy offered in conjunction with a new federal health insurance tax credit or deduction would obviously be administered differently from assistance offered as part of a state-operated public insurance program. However, two fundamental concerns arise in considering any ESI subsidy proposal:

- Should assistance be provided to currently insured workers, or only to those who have not previously taken up coverage?
- How can employers be prevented from reducing their contributions for subsidy-eligible workers to take account of any new public funds?

This paper begins with a general discussion of these basic questions. It then considers other elements of program design, using for illustration one specific option, an ESI tax credit designed as an adjunct to a general income-based health insurance tax credit for non-group coverage. While this option will be considered in the greatest detail, an effort will also be made to show how different design decisions might be appropriate in the context of a state-administered program.

#### TREATMENT OF THE CURRENTLY INSURED

Most people, even those with very low incomes, who are offered ESI accept it. If one excludes individuals who had some other form of coverage (such as Medicare or Medicaid), the take-up rate for ESI by families below 100 percent of poverty in 1996 was 70 percent, and 80 percent for those from 100 to 200 percent of poverty.<sup>6</sup> A program offering ESI subsidies for every family below a given income limit might reach three or four currently insured people for each previously uninsured person newly covered.<sup>7</sup> This might well be more costly than covering the uninsured people directly, through a public program or non-group tax credit.

For this reason, proposals to subsidize ESI often seek to exclude the currently insured. For example, federal guidelines for states using SCHIP funds to provide ESI assistance allow assistance only for children who have not had ESI during a period of 6 to 12 months prior to applying.

As Zelenak points out in rejecting a similar restriction on eligibility for a non-employer tax credit, the rule is difficult to enforce, and it penalizes people who have lost employer coverage involuntarily.<sup>8</sup> Perhaps more important, the rule is patently inequitable. Workers who have previously declined ESI would receive assistance. Co-workers at the same income level who may be paying a significant amount for coverage would have to go on doing so—or would have to go without insurance for some period in order to qualify for assistance.

The model presented in this paper comes down on the side of equity and would allow subsidies for low-income families who are already receiving ESI. In consequence, most of the new public spending would go for the currently insured, and the cost per newly insured person would be quite high. This might be politically fatal in the current environment. While fairness is important, there are many inequities in the current system; Congress and states are likely to give greater priority to efficient use of limited funds.

Finding an appropriate balance between equity and targeting may depend on whether one conceives of a new initiative as a short-term, stopgap measure to reach some share of the uninsured, or as a program that might have a permanent place in our health financing system. The SCHIP guideline, excluding the currently insured, reflects the legislative intent to use a fixed amount of funds to achieve immediate reductions in the number of uninsured children. While attempting to lock out the currently insured makes sense in this context, it may not be tenable over a longer term, for several reasons.

First, people change jobs, enter and leave the workforce, go on and off public programs. Coverage is especially unstable for the lower-income workers likely to be the target of a subsidy program. Among people below 200 percent of poverty who had employer coverage at any time during 1996, one-third had coverage for only part of the year; 89 percent of higher-income people with employer coverage retained it for the entire year.<sup>9</sup> A “firewall” rule that locks out the currently insured might be effective over a brief period, but its effects would diminish over time.

Second, as noted earlier, an ESI subsidy is likely to be offered in the context of some broader coverage initiative, such as a tax credit for non-group health insurance or expanded public coverage. If a non-group tax credit is very generous, or if a comprehensive public program is available at little or no cost, many modest-income workers might be better off shifting to employment that offered higher wages or other benefits in place of health insurance. In the long term, it must be expected that employers seeking to attract these workers would modify their compensation schemes accordingly. If

ESI is less beneficial to the workers than wages or other benefits, it will gradually erode. Whether an ESI subsidy can shift the balance enough to prevent this erosion will be considered at the end of this paper.

## POSSIBLE EMPLOYER RESPONSES

A new public program offering to cover some or all of the employee's share of premium costs will give employers an obvious incentive to modify their contribution schemes. This would be easier in a low-wage firm, where most workers might qualify for ESI assistance. The employer could simply raise the required employee share to the maximum amount of assistance available. It seems less likely that mixed-wage firms, in which some, but not all, workers qualify for a subsidy, would respond in this way: presumably they would not reduce contributions for all employees to take account of a benefit available only to a few of them. However, there may be opportunities for mixed-wage firms to isolate subsidy-eligible workers. If a firm could reduce contributions for these workers while holding other employees harmless, it might well have an incentive to do so. (Possible loopholes in current nondiscrimination rules are described in appendix B.)

This is a formidable objection to ESI subsidies, and there is no entirely satisfactory solution. Employers cannot simply be forbidden to reduce their contributions. A state rule of this kind would be preempted by ERISA, while a federal rule requiring that employers forever continue to pay what they do now is politically inconceivable. Some proposals would try to achieve the same effect indirectly by providing that assistance with ESI could be furnished only if an employer has not reduced its contribution level during some recent period. Employers could not then cut their contributions without injuring their workers by rendering them ineligible for assistance. However, enforcement would require some form of universal tracking of employer contribution levels over time; adoption of such a system seems unlikely.

One alternative is to set the ESI subsidy at some percentage of the required employee contribution, rather than the full amount. For example, the subsidy might cover 50 percent of the employee share; if an employer reduced its contribution by \$100, the employees themselves would face \$50 in additional cost. Presumably—at least in a full employment market—employers could not unilaterally reduce compensation in this way. However, the employer could make up the \$50 difference by raising wages and would still save money.<sup>10</sup> The incentives for employer gaming could be removed only by reducing the ESI subsidy to a very small share of the required employee contribution. As workers now declining available ESI are likely to be in the firms that already make the lowest



contributions, the reduced ESI subsidy would fail to fulfill its initial goal of improving participation.

The SCHIP guidelines for ESI subsidies suggest another way to prevent employer gaming. A state may provide a subsidy only when the employer is contributing a specified minimum percentage—generally 60 percent—of the premium for family coverage.<sup>11</sup> A rule of this kind would at least prevent some precipitous reductions in employer contributions, though it would not keep employers above the threshold from dropping to the minimum. However, there would then be the question of what to do with workers whose employers are already contributing less than the minimum. If they cannot receive the ESI subsidy, should they instead be allowed access to a public program or tax-subsidized non-group coverage? The answer is clearly yes: it would be unacceptable to lock workers into employer plans that expose them to very high costs while providing assistance to people in more generous employer plans.

However, the rule then becomes self-defeating. Even if an employer only contributed, say, 40 percent of the premiums, it would be cheaper for the government to pay the other 60 percent in the form of an ESI subsidy than to pay 100 percent of the cost of public coverage or a tax credit.<sup>12</sup> There is also a risk that some low-wage employers will simply drop their contribution below the threshold to encourage their workers to shift into the public program.<sup>13</sup>

Despite these important drawbacks, the minimum contribution rule seems the most workable option, and it is adopted in the model presented in the next section.

## A SUBSIDY MODEL AND VARIANTS

### Basic Model

A refundable ESI credit (ESIC) would be provided as an adjunct to the program of income-based tax credits for non-group coverage described by Larry Zelenak.<sup>14</sup>

Under the Zelenak proposal, a refundable credit averaging \$2,000 for single coverage and \$4,000 for family coverage would be available to anyone with family income below about 200 percent of the federal poverty level. The amount of the credit would be adjusted for the age and sex of the tax filer; the credit would gradually phase out as income rose above 200 of poverty.<sup>15</sup> The credit could only be used to purchase private non-group coverage and could not be applied to ESI. However, current ESI participants meeting the income test would be free to drop their ESI and shift to subsidized non-group coverage.

The ESIC would be targeted to workers in approximately the same income range who have access to ESI. The key features are as follows:

- The ESIC would be available to people who have access to ESI with a minimum employer contribution of at least 70 percent of the cost for single coverage or 50 percent of the cost for family coverage.
- No one eligible for the ESIC would be allowed to participate in the non-group credit program.
- The ESIC would be equal to the lesser of (a) the worker's required ESI contribution for single or family coverage or (b) an income-based maximum amount. The formula for computing this cap is described below. Unlike the non-group credit, the ESIC would not be age-adjusted.
- The ESIC would be administered by the Internal Revenue Service. Taxpayers could claim it in their annual return or could obtain advance payment during the year from their employers, through a process comparable to that used for advance payment of the earned income credit (EIC).

### Eligibility

Anyone within the income limits for the non-group credit, whether or not currently insured, would be eligible for the ESIC if the employer was contributing 70 percent of the cost for single coverage or 50 percent of the cost for family coverage. Workers with access to ESI not meeting the minimum contribution standard could not obtain the ESIC, but would be eligible for the non-group credit if they chose to obtain coverage outside their employer plan.

Setting the minimum employer contribution. The minimum contribution levels are arbitrarily set about 10 percentage points below the national average employer contribution in firms with a high proportion of low-income workers.<sup>16</sup> Even if the minimum contribution is set at 10 percent below the average, the ESIC will be unavailable for a great many employer plans. Ineligible plans will be more prevalent in different industries, firm sizes, and regions. For example, the average employer in the West (whether or not low-wage) contributes 69 percent toward single coverage, less than the specified threshold. Ideally, the minimum contribution might be set in relation to prevailing contribution levels in comparable firms, defined by a number of parameters.

This would be unwieldy for a national tax credit, but a state program could take account of local employer practices.

Requiring that workers accept ESI. Should people with access to ESI that meets the minimum contribution requirement be required to take the ESIC, or could they instead choose to obtain the non-group credit and seek coverage outside their employer plans? Similarly, if an ESI subsidy were available in the context of a public insurance program, could a worker opt for the public coverage instead of enrolling in the employer plan?

Since one of the basic arguments for an ESI subsidy is that it is more cost-effective to draw on available employer contributions than to provide coverage entirely with public funds, it would seem to make sense to require that people accept ESI when it is available. Moreover, if people can choose between ESI and alternative coverage, there are potentially undesirable risk-selection effects.

This is particularly true in the basic model examined here, which is tied to a very generous tax credit for non-group coverage. In most states, non-group insurers may vary premiums according to age, health status, or other factors, while employee contributions to ESI may not vary by health status.<sup>17</sup> Although non-group coverage can cost as much as 30 percent more than group coverage for comparable benefits, the discounts available to younger and healthier purchasers of non-group coverage more than offset this difference (except in the very few states with stringent rating regulation). Low-risk workers eligible for the maximum non-group credit might be able to find coverage that is much more generous than their current employer plan. In the Zelenak proposal, this risk is mitigated, because the non-group credit would be age-adjusted. However, non-group insurers could offer more attractive rates and enhanced benefits to the lowest-risk applicants within each age group. The departure of the healthiest workers from the employer plan would raise average costs for those remaining in the plan.<sup>18</sup>

If, on the other hand, a subsidy for non-group coverage were accompanied by some form of community rating requirement in the non-group market, the post-subsidy cost for the highest-risk workers could be less than the amount their employer is now contributing to their ESI. Employers might encourage their high-cost workers to shift to non-group coverage by negotiating some increase in wages or other benefits on an individual basis.<sup>19</sup> The same could occur if the alternative to ESI were some form of public plan.

On balance, it seems reasonable that people with access to ESI should be made ineligible for the non-group credit, and this provision is included in the basic model. However, the rule is likely to be unacceptable to a number of key stakeholders. Obviously non-group insurers would be unhappy, because they would lose a large share of the new market created by the non-group credit.<sup>20</sup> At the same time, mixed-wage employers would have to continue paying for health benefits for workers who would otherwise have given up their ESI. They would also have to cover any new participants who would have declined ESI in the absence of the ESIC.

More broadly, many of the people who advocate tax benefits for non-group coverage do so in the name of promoting freedom of choice. They believe that individuals should be free to select their own preferred carrier and level of benefits, rather than having to take a one-size-fits-all plan selected by their employer. Some support for a tax credit could evaporate if it were accompanied by a rule that would defeat this basic objective.

**Interaction with SCHIP.** The non-group family credit is set at twice the amount of the single credit on the assumption that most children in families within the income limits for the credit are eligible for SCHIP. It thus contemplates that families will have split coverage, with parents in non-group plans and children in SCHIP. The ESIC for families below the phaseout level is so generous that it should usually cover the full employee contribution for family coverage. Most families with SCHIP-eligible children would probably enroll their children in the employer plan. This is not inherently undesirable. More children would probably become insured if parents could enroll them in an employer plan instead of having to apply separately for SCHIP coverage. In addition, families would be better able to navigate managed care systems if all family members were in a single plan. However, a shift of children from SCHIP to tax-subsidized ESI would have two drawbacks.

First, the state contribution toward SCHIP would be lost; the ESIC would be paid entirely with federal dollars. However, it is likely that the incremental cost of covering children through the ESIC would be less than the federal share of the cost of covering the same children through SCHIP.<sup>21</sup> The trade-off could be evaluated over time; if there was a real federal loss, this could be made up through adjustments in the SCHIP grant allocations or matching payment formula.

Second, children in employer plans might not receive the preventive care and other minimum benefits available under SCHIP. Whether there should be any minimum benefit standard for employer plans is discussed in the next section. In the absence of any

standard, SCHIP might function as a supplement to the employer plan. This would require a change in SCHIP rules, which currently preclude the use of the program as a supplement for children with other coverage.<sup>22</sup>

### Coverage and Plan Standards

If people with access to ESI are required to accept it, should there be some minimum benefit standards for the employer plans? Should people with access only to a “substandard” plan, however defined, be allowed instead to choose coverage under the non-group credit or a public plan?

In the basic model, tied to a non-group credit, the answer is probably no.<sup>23</sup> It is true that some people might have to accept a plan less comprehensive than the one they could have purchased with the non-group credit. However, the non-group credit proposal itself does not guarantee that every credit participant will be able to purchase any particular level of benefits. Those who are high risk, or who live in high-cost areas, would probably be able to obtain only plans inferior to most employer coverage. So the enrollees most disadvantaged by a lock-in to employer coverage are the lower-risk workers—precisely the group whose migration out of ESI the lock-in rule is meant to prevent. Moreover, a minimum benefit standard for a national program providing funds for ESI would face considerable opposition. Even though the standards would apply only to plans purchased with the ESIC, they would likely be seen as the entering wedge for more general standards for employer plans.

The issue is more difficult when the alternative to ESI is a public program that furnishes some particular level of benefits (or a non-group credit available only for plans meeting some minimum standards). Under SCHIP, for example, state public programs must provide coverage equal to a specified benchmark, and there are restrictions on the amount of copayments or other cost sharing that may be imposed. States that choose to provide ESI assistance must assure that the children in employer plans receive coverage that meets these requirements. This means that the state must either provide assistance only for plans meeting the standards or must somehow supplement substandard employee plans, for example by providing “wraparound” coverage through the public program.<sup>24</sup> Compliance with these requirements is extremely cumbersome. The state must somehow assess the benefits under each employer plan, and administration of a wraparound program is also complicated.<sup>25</sup>

Whether minimum standards are appropriate may depend in part on the goals of the program. An insurance program such as SCHIP, one of whose major goals is to

improve access to preventive and well-child care, would reasonably take steps to assure that children in employer plans not face any barriers to these services. A program targeted at adults or at families with somewhat higher income levels might emphasize general improvement in access and financial protection, rather than access to any specific set of services.

### Amount and Structure of the Subsidy

**Basic credit amount.** There are a variety of ways in which the credit amount could be established. The simplest would be to set the credit at the lesser of (a) the actual premium contribution made by the worker or (b) the maximum non-group credit for a worker with the same income. There are at least two possible objections to this method:

1. Most workers receiving the ESIC would be better off than those who receive the non-group credit and buy non-group coverage.

Because non-group coverage is more costly than equivalent group coverage, even recipients of the maximum non-group credit would probably have to pay more than the credit amount to receive benefits comparable to those offered in a typical employer plan. In addition, workers with incomes in the phaseout range might pay nothing for their ESI, while workers at the same wage level receiving the non-group credit would have to contribute toward the cost of their coverage.<sup>26</sup> If the aim were absolute equity, one would wish to ensure that the ESIC recipient was left *neither better nor worse off* than the non-group credit recipient. The ESIC might be adjusted for estimated differences in group and non-group benefit values, or might be reduced so that workers above the phaseout range would have to contribute something toward their coverage.<sup>27</sup> Neither of these adjustments has been adopted here, because part of the aim of the ESIC is to encourage people to remain in jobs that offer ESI; they are more likely to do so if ESI retains some advantages.

2. The total federal cost—including the ESIC and the existing tax subsidy for the employer's share of the premium—could be more than the cost of the non-group credit for someone with the same income.

Employer contributions to health insurance are excluded from workers' taxable income for both income tax and Social Security/Medicare payroll taxes. If an employer contributed 70 percent of a \$2,000 premium for single coverage, or \$1,400, the tax subsidy for this contribution would be \$424 (for a worker in the 15 percent tax bracket). If the ESIC covered the employee's \$600 share, total federal spending would be \$1,024.

This is equal to the available non-group credit for a single person at about 275 percent of poverty, and considerably more than the credit for people with higher incomes.

The ESIC is most likely to cost the federal government more than the non-group tax credit for workers with incomes in the phaseout range. For lower-income workers, the sum of the ESIC and the income/payroll tax subsidy would exceed the non-group credit only if the employer plan were exceptionally expensive.<sup>28</sup>

A precise adjustment for this problem would require a cap on the ESIC based on the worker's income and the amount of the tax-subsidized employer contribution. While a cap could be computed fairly easily, the resulting credit tables would be dauntingly complex. The solution adopted here is to cap the ESIC at an amount equal to (a) the average non-group credit for a worker at the same income level minus (b) 80 percent of the worker's required ESI contribution.<sup>29</sup> For example, if the worker's income were 300 percent of poverty and the worker's ESI contribution were \$600, the ESIC would be the average non-group credit of \$732 minus \$480 (80 percent of \$600), or \$252.

Unlike the non-group credit, the ESIC would not be adjusted for age and sex. This adjustment makes sense for the non-group credit, because it equalizes the buying power of different participants in a market that customarily uses age and sex in setting premiums. Required employee contributions usually do not vary by age and sex in a given firm; an adjustment would underpay younger workers and overpay older ones. The omission of the age adjustment does disadvantage workers in firms with predominantly older enrollees, if these workers therefore face higher contribution requirements than workers in firms with younger or mixed-age employees.

Treatment of couples and families. The ESIC for family coverage would be computed similarly, except that the cap would be equal to the non-group credit for a family at the same income level minus 40 percent of the ESI contribution. Like the non-group credit, the ESIC would not vary by number of family members covered under the employer plan.

A couple with two earners, both eligible for ESI through their own firms, could apply the credit to employee-only coverage under both plans or to employee-plus-dependent coverage under one of the plans. This rule is probably not ideal; it may encourage more employers to adopt the rule, already in place in some firms, that a worker may not cover a spouse who is eligible for ESI elsewhere. However, requiring that a couple choose one employer plan could increase credit costs, because the required

employee contribution for family coverage will often exceed the sum of contributions for employee-only coverage in two plans.

Finally, computing the credit for workers with a choice of plans or with access to flexible benefit arrangements raises some technical issues; these are discussed in appendix C.

### Administration

Administering an ESI subsidy through the tax system is fairly straightforward. Perhaps the most difficult problem is obtaining the necessary information to enforce the requirement that people claiming the non-group credit not have access to ESI. Administration of an ESI subsidy provided directly by a state or other public program presents very different issues. Appendix A provides a brief review of key concerns that have arisen under Medicaid and SCHIP ESI assistance programs.

The ESIC would be administered in much the same way as the earned income credit (EIC). Workers could claim it on their annual tax returns or could receive advance payment through their employers.

*Advance payment.* The system would work as follows:

- An employee would request advance payment by submitting a form resembling the W-5 used for the EIC.
- The employer would determine the employee premium contribution for the type of coverage the employee selected (single or family); it would then determine the advance credit amount using IRS tables based on the required contribution and the employee's wages. The advance payment would be made in each paycheck, partially or fully offsetting the employee premium contribution deduction in the same paycheck.
- The employer would deduct advance ESIC payments from its periodic payment of Social Security and Medicare employment taxes. As with the EIC, if the advance payments exceeded employment tax liability, the employer could reduce the advance ESIC payment or apply the excess to future employment taxes.
- Advance payments would be reported on the employee's W-2 and by the employee on the 1040 form. Over- or underpayment of the advance ESIC would be reconciled in the final computation of tax payable or refund due.



Is advance payment worth the trouble? The amounts involved will often be fairly small. ESIC recipients who already have taken up ESI are somehow managing their current contributions and would presumably continue to do so if they had to wait until the end of the year for a credit. However, advance payment could encourage take-up by workers who have previously declined ESI, and administration through payroll systems is considerably simpler than the voucher system proposed for the non-group credit.

Some participants would have to repay excess advance payments during the annual reconciliation process. As Zelenak suggests, this may be burdensome for workers who have seriously underestimated their income. However, it is likely that workers with access to ESI have more stable employment and income than other workers, so the problem may not be as great as under the non-group credit. In addition, the amounts involved should be smaller.

The need for a reconciliation process would be obviated if the final ESIC amounts, like the advance payments, were based on the worker's wages, rather than on modified adjusted gross income. However, a great many low-wage workers have multiple jobs or are in families with multiple earners. In 1998, one-third of all workers earning less than \$15,000 from the job they spent the most time on were in families with incomes above 200 percent of poverty.<sup>30</sup> Basing the credit on one worker's earnings at one particular job would dilute the income-targeting of the ESIC, and would also encourage families with ESI access through two family members' employment to shift to the plan of the lower-paid worker.

**Additional employer reporting.** The IRS would need to know three things to determine the credit amount for a taxpayer claiming it at the end of the tax year (and for reconciliation): (a) the amount of the premium contributions the taxpayer made during the year; (b) whether these contributions were for single or family coverage; and (c) the taxpayer's modified adjusted gross income (MAGI). All of this information could simply be supplied by the taxpayer on a new 1040 schedule, but it would be useful for both the taxpayer and IRS to have the amount of the premium contribution reported by the employer on the W-2 form. This should not be difficult for most employers, since pay deductions for health insurance are commonly made through the same payroll system that ultimately generates the W-2. When employers make a fixed contribution to a union plan, however, they may not know what amount, if any, the employee is contributing. Separate reporting by the plan administrator might be needed.

For the purpose of enforcing the minimum employer contribution rule, it would also be appropriate for the W-2 to include either the amount of the employer contribution or the total cost of the plan.<sup>31</sup> This would be burdensome. Unlike employee contributions, employer contributions are not tracked through the payroll system; new data collection systems would be needed. The alternative, enforcing the rule through random audit, is even less satisfactory. If it turned out that a worker had claimed the ESIC for a plan not meeting the employer contribution requirement, who would be held responsible? Workers may have no idea what their employer is contributing toward their coverage. At the same time, employers contributing less than the minimum might have no idea that their workers were inappropriately claiming the credit (although they could at least be expected not to pay advance credits if they know their plan doesn't meet the test).

Determining access to ESI. If people with access to ESI are made ineligible for the non-group credit, how could this rule be enforced? A similar rule already applies to the current federal health insurance tax deduction for the self-employed; the deduction is unavailable to people who are eligible for ESI directly or through a spouse. This rule is, like most of the rest of the tax code, enforced through self-reporting, with random audits. Should there be a more systematic attempt to verify access to ESI?

States have tried to enforce similar eligibility restrictions for SCHIP or state-only programs in a variety of ways. Some verify employment, for example through data matching with the unemployment insurance agency, and then contact employers individually to determine whether ESI is available. This would obviously be a cumbersome way of administering a tax credit available to a large segment of the population.

Alabama is developing a system to track coverage of most of the state's population, using data voluntarily supplied by insurers. The IRS could establish a similar system by requiring that employers report availability of ESI on each worker's W-2. Reporting would be needed for every worker, as employers would have no way of knowing which employees were receiving the non-group credit. In addition, many people are eligible for ESI during only part of a year and would be eligible for the non-group credit the rest of the time. The employer would therefore have to report the actual time period of ESI eligibility. Such a burdensome system would face serious political barriers. In 1993, Congress actually enacted a requirement that all employers report to HCFA on workers and dependents receiving ESI; the aim was to identify Medicare and Medicaid beneficiaries for whom ESI might be the primary payer. The requirement expired at the end of 1997 without ever having been implemented, chiefly because of complaints by employers about the workload involved.

Because verifying ESI access is difficult, most states with exclusionary rules have tended to use an honor system, relying on information supplied by the applicants themselves. The IRS would probably have to take a similar approach, despite the risks of gaming. A thorny problem that will not be resolved here is just what penalty non-group credit recipients should face if they are found to have had access to ESI. Should they repay the whole credit, or perhaps just the excess over what they would have received under the ESIC?

Open enrollment. Workers who do not accept ESI when they initially become eligible but who wish to enroll later usually must wait for an annual open season. As a start-up provision only, employers might be required to allow workers to enroll in ESI at the beginning of the first tax year for which the ESIC was available.

### EVALUATING THE OPTION

The usual measure of success for an incremental coverage expansion is the number of newly insured people per dollar spent. If considered in these terms, the combination of a non-group credit and an ESIC may in the short term be less efficient than a non-group credit alone. The table below compares the effects of the two options, using the simulations prepared for this project.

Effect of Adding the ESIC to the Basic Non-group Credit

	Non-Group Credit Alone			Non-Group Credit + ESIC		
	Number of People (millions)	Percent of Insurance Category	Net Cost (in 1999 \$ millions)	Number of People (millions)	Percent of Insurance Category	Net Cost (in 1999 \$ millions)
Total Cost (\$1999)	—	—	25,877	—	—	40,797
Total Take-up of Subsidy	22.8	9.4	—	68.7	28.4	—
Previously non-group	8.1	49.6	10,592	7.1	43.3	7,614
Previously uninsured	8.4	17.7	11,287	11.8	24.7	11,718
Previously employer-insured	5.3	3.6	4,341	48.7	33.3	22,187
Previously Medicaid	1.0	3.4	-344	1.2	4.1	-835
Total Change in Population Size						
Non-group	14.7	89.6	—	5.7	34.6	—
Uninsured	-7.9	-16.7	—	-11.2	-23.5	—
Employer-Insured	-5.8	-3.9	—	6.7	4.6	—
Medicaid	-1.0	-3.4	—	-1.2	-4.1	—
Cost per Newly Insured (1999 \$)	—	—	\$3,258	—	—	\$3,643

Adding the ESIC reduces the proportion of workers with ESI who would shift to non-group coverage if the non-group credit were the only option available. At the same

time, it induces many more uninsured people to take up coverage, both because enrollment through an employer plan is more convenient and because the combination of employer contributions and the ESIC leaves more potential participants with little or no out-of-pocket cost than would the non-group credit alone. Still, most of the new spending would go for families that have already taken up ESI. As a result, the estimated cost per newly insured person is \$3,643, compared to \$3,258 for the non-group credit alone. While the per capita difference is only about 12 percent, the overall cost of adding the ESIC, in 1999 dollars, is nearly \$15 billion more than the cost of the non-group credit alone.

Spending money for modest-income people who are already insured can be defended on equity grounds; it would be unfair to extend free coverage to people without ESI while ESI participants at the same income level are making steadily higher contributions toward the cost of their coverage. But there are many inequities in the current system—such as the higher tax subsidy for coverage of the highest-paid workers. If the total amount the nation is prepared to spend is limited, it might seem reasonable to target funds to the uninsured before attempting to correct these imbalances.

It is possible that the simulation understates the potential for coverage shifting under the non-group credit alone. It assumes that workers with ESI cannot individually negotiate higher wages in exchange for dropping their ESI and shifting to the non-group credit. Instead, a “cash-out” is assumed to occur only if all the workers in a firm would, on average, benefit from this change. As was suggested earlier, individual negotiation is certainly conceivable, especially in very small firms. More important, the incentives created by the non-group credit would be expected over the long run to lead to erosion of ESI for low-income workers. Employers seeking to attract workers who are eligible for the maximum non-group credit would do better to offer higher wages or other benefits instead of ESI.

The likelihood that this will happen is directly related to the generosity of the publicly funded program. If the tax credit is stingy or a public insurance program imposes significant premiums, ESI might retain its current advantages for most workers. The trade-off is that increasing costs for programs other than ESI to prevent shifts out of ESI will also reduce take-up by the currently uninsured without ESI access.

The problem, then, is one of balancing the potentially conflicting goals of providing adequate public support for low-income people while retaining the advantages of ESI. ESI may be a good way of organizing and administering health insurance, because of economies of scale, pooling of risks, and ease of participation. It is not a very good way

of financing coverage for low-income people, because they are effectively paying for the coverage themselves, with limited support from the current tax preference. (This support itself is more beneficial to workers in higher tax brackets.) If public funds are to play a larger role in assuring coverage for workers below a given income level, it is not clear why access to these funds should depend on where someone works.

This view has led to proposals that would provide the same level of public support to people with a given income regardless of how they obtained coverage. The tax preference for employer-paid coverage would be eliminated, and the savings used to provide a uniform income-based credit that could be used for either ESI or non-group coverage.<sup>32</sup> These proposals raise serious concerns. Even if employers continued to offer a plan, healthier workers might find that they could get better rates by leaving their groups. Some might enroll in less comprehensive plans, while many more might forgo coverage altogether. Meanwhile, higher-risk workers would be left behind in a steadily deteriorating employer risk pool. (These effects could be mitigated, but probably not eliminated, by insurance market reforms and/or development of new pooling mechanisms.)

The ESIC considered here represents a middle solution, putting some additional public funds into the employer-based system. It is not large enough to completely remove any incentive for coverage shifting. To the extent that workers forgo wages in order to obtain an employer contribution to ESI, a credit that assists only with the employee share of premiums will still leave many of these workers worse off than if they could find a job with higher wages and no ESI.<sup>33</sup> The ESIC proposal would therefore include a rule locking workers into available ESI, at the price of leaving many of these workers comparatively disadvantaged. Still, it is more equitable than either the current system or a system that provides expanded public assistance only to people without ESI access.

Even this compromise solution entails significant short-term costs for people who are already covered. While it might be true that the non-group credit could lead to steady erosion of ESI, the market could take many years to respond fully to the new incentives, while the ESIC would begin costing money right away. Moreover, there is no sure way to prevent at least some employers from capturing the new federal dollars by increasing required employee contributions. Still, it seems advisable that any large coverage expansion using public funds include at least some additional public support for low-income ESI participants. A system that permanently disadvantages low-income workers with access to ESI is unlikely to be sustainable over the long term.

## APPENDIX A. PREMIUM ASSISTANCE UNDER MEDICAID AND SCHIP

Public assistance with employee premium contributions is currently available to a limited extent under Medicaid and under the federal/state Children's Health Insurance Program (SCHIP). Federal rules for premium assistance under Medicaid and SCHIP share two key provisions:

- The assistance must be cost-effective: the government contribution to the employer plan may not exceed what would have been spent for comparable benefits for a comparable individual enrolled in the public Medicaid or SCHIP program.<sup>34</sup>
- If the employer plan does not provide all of the benefits available under the public program, the state must provide some form of wraparound coverage. In addition, it must assure that cost-sharing amounts paid by the family do not exceed allowable cost sharing under Medicaid and SCHIP.

If these two conditions are satisfied, a state may provide Medicaid premium assistance to anyone eligible for Medicaid benefits, including someone already participating in an employer plan at the time of application.<sup>35</sup> The SCHIP statute, on the other hand, limits assistance to children who are currently uninsured. Guidelines issued by DHHS establish further restrictions intended to limit substitution of SCHIP funds for current private spending. First, assistance is not permitted for a child who has had employer coverage in the last six months (or up to twelve months at state option). Second, assistance is generally allowed only when the employer contributes at least 60 percent of the cost of family coverage.

These requirements can make premium assistance quite complex to administer.

- *Getting information about the employer plan.* Applicants for assistance, particularly those who have not previously taken up ESI, are unlikely to have the necessary information on available coverage, benefit packages, and required employee contributions. States therefore contact employers directly to obtain the information; most report that employers are generally cooperative. The state must then assess cost-effectiveness on a plan-by-plan and enrollee-by-enrollee basis; some states have automated this process and are maintaining data banks on employer plans so that it need not be done repeatedly.

- *Issuing reimbursement.* States generally reimburse participants directly for their premium contributions. They have found that employers do not wish to receive reimbursement, partly because of the administrative burden of handling payroll deductions differently for different employees. The workers themselves may not wish their employers to know what reimbursement they are receiving, and some states feel that employers are less likely to modify their own contributions if the process is invisible to them. Several states attempt to time their payments so that participants are reimbursed before the health insurance deduction is taken from their paycheck. When advance payment is made in this way, states must somehow verify that the participant actually used the payment for coverage. One state requires that participants periodically submit pay stubs showing the health insurance deduction. Another has developed a system for matching with health insurers' records, although only a few carriers are participating.
- *Filling in missing benefits.* The state must assure that participants receive all the benefits they would have received under the public program. The Massachusetts program provides one example of how this can be done. First, the state reviews each employer benefit package to assure that coverage in each service category is as comprehensive (except for required cost sharing) as the coverage in the public program. Assistance is not provided for plans that fail this test. The state must then assure that covered children do not pay cost sharing beyond SCHIP limits, which forbid any cost sharing for well-child services and also impose income-based limits on total cost-sharing. Participants are instructed to have their providers bill the state directly for SCHIP-prohibited copayments, and receive a kit that helps them track and record their aggregate cost-sharing.

These administrative complexities have limited states' use of premium assistance. While many state Medicaid programs provide assistance, most have found the process so cumbersome that they assist only a small number of seriously ill beneficiaries who can be expected to incur very high costs. A few states have much broader programs; Iowa, for example, is providing assistance to about 8,000 beneficiaries.

Only three states so far—Massachusetts, Mississippi, and Wisconsin—have included ESI assistance in their SCHIP plans.<sup>36</sup> Only the Massachusetts program, which uses both Medicaid and SCHIP funds, is fully operational. As of December 1999, 4,200 people were enrolled.<sup>37</sup> Oregon operates a premium assistance program with state-only funds, serving 6,500 people as of February 2000; it has applied for federal approval to use SCHIP funds for this program. Because these programs are new and still quite small, it is too early to know whether they have saved any money (compared to providing benefits directly) or what changes in employer and employee behavior they may have induced.

## APPENDIX B. OPPORTUNITIES FOR DISCRIMINATION BY MIXED-WAGE EMPLOYERS

Mixed-wage firms, in which only some workers might qualify for ESI assistance, would not be expected to modify their contribution policies for all workers in order to take advantage of a subsidy available to only some of them. However, they would have an incentive to adopt different policies for workers who were and were not eligible for assistance. While there are some nondiscrimination rules for employer plans, it is not clear that they are sufficient to prevent at least some employers from isolating subsidy-eligible workers.

Existing nondiscrimination rules under HIPAA (and, for self-insured employers only, under the Internal Revenue Code) might prevent an employer from simply offering ESI to credit-ineligible workers and not to credit eligibles, or from varying its contributions for the two groups. Still, an employer may have some ability to establish classes of workers according to factors that may be closely related to credit eligibility. Under HIPAA, for example, an employer can apparently offer different benefits to different occupational classes; obviously these correlate with income.<sup>38</sup> The stricter rules for self-insured plans still allow exceptions for workers with less than 3 years of service, part-time or seasonal workers, and workers under age 25. There may also be separate plans for workers covered and not covered under a collective bargaining agreement. These exceptions might allow at least some employers to change their contribution schemes for workers most likely to qualify for the ESIC.

Federal regulation could be strengthened, though the political barriers are formidable. At a minimum, the occupational class loophole in HIPAA could be closed. It would also be desirable to extend to insured employers the limited nondiscrimination rules already applied to the self-insured. Congress actually did this once, in section 89 of the 1986 Tax Reform Act. However, this section also included much more stringent nondiscrimination rules, and was repealed in its entirety after an outcry by employers.<sup>39</sup> It might be possible to revisit the more modest goal of equalizing treatment of the two types of employer plans.

Even in the absence of overt discrimination in contributions, tax-favored flexible spending accounts (FSAs) might offer a mechanism through which mixed-wage employers could effectively reduce their contributions for credit-eligible workers without affecting higher-income workers. An employer could (a) raise required employee contributions for all workers, (b) raise wages by the same amount only for those workers ineligible for the



credit, and (c) let those workers make their contributions through an FSA, while the credit-eligible workers use the ESIC. It is not clear how this kind of gaming could be prevented without simply eliminating FSAs as a method of paying employee premium contributions.

## APPENDIX C. MULTIPLE CHOICE AND FLEXIBLE BENEFIT PLANS

Computing the credit is complicated by the fact that many workers have a choice among several health plans, usually at different prices to the worker. Many also have access to cafeteria plans—under which a worker may choose among different health insurance options, other benefits, or cash—or to flexible spending accounts, through which the worker may pay the required share of ESI premiums with tax-exempt dollars.<sup>40</sup>

In multiple choice plans, should the credit be available for the full contribution to any plan selected by the employee, or should it be limited to the cost of the least expensive option? In the absence of a cap, workers in firms that offer a choice of plans might use the credit to obtain more generous benefits or shift to a less restrictive provider network. This would raise costs not only for the ESIC itself but also for employers: most employers subsidize at least part of the extra cost of more expensive options.<sup>41</sup> It seems fairer to limit the ESIC to the cost of the least expensive option, leaving the worker to pay out-of-pocket any differential for more costly plans. However, this requirement is so difficult to administer that it will not be adopted here.

In cafeteria plans that allow a choice of health benefits or higher wages, has a worker who chooses health benefits effectively paid for them by forgoing the wages? If so, should the ESIC compensate the worker? This is a tough call. As it happens, however, the Zelenak proposal adopts an income-determination methodology that treats as countable income the value of the wages the worker could have received in lieu of benefits.<sup>42</sup> It would therefore be consistent to treat the forgone wages as an employee contribution subject to reimbursement through the ESIC.

Under a flexible spending account (FSA) arrangement, the employee designates a sum to be deducted from his or her wages and deposited into the FSA; the amount deposited is non-taxable. The employee may then draw on the account to pay for his or her share of health premiums. If the ESIC reimbursed the full premium contribution, workers would receive a dual tax benefit. In addition, because the FSA deposit reduces adjusted gross income, workers in the phase-down range would get a higher ESIC than they would have received in the absence of the FSA. These effects could be addressed by adjusting the ESIC amount, at the price of complicating the system.

## NOTES

<sup>1</sup> Author's calculations, based on the Medical Expenditure Panel Survey (MEPS). The coverage estimates are for January 1996; family income is for the entire year. The estimate assumes ESI was available for spouses and minor children of workers who were offered coverage. About 37 percent of the uninsured in this group were family members of workers who had obtained ESI for themselves but not for dependents.

<sup>2</sup> Henry J. Kaiser Family Foundation and Health Research and Educational Trust (KFF-HRET), *Employer Health Benefits: 1999 Annual Survey*, Washington, D.C., 1999.

<sup>3</sup> KFF-HRET and C.L. Peterson and J.P. Vistnes, *State Differences in Job-Related Health Insurance, 1996*, Rockville (MD): Agency for Healthcare Research and Quality, 2000. MEPS Chartbook No. 4. AHRQ Pub. No. 00-0017.

<sup>4</sup> The Commonwealth Fund, Task Force on the Future of Health Insurance for Working Americans, *Listening to Workers: Challenges for Employer-Sponsored Coverage in the 21st Century*, New York, January 2000.

<sup>5</sup> The latter approach is part of the insurance reform proposal advanced by the Health Insurance Association of America. See <http://www.insureusa.org/plan/proposal.htm>, 1999.

<sup>6</sup> Author's analysis of 1996 MEPS.

<sup>7</sup> The ratio could be even higher if, as is likely, the currently insured take up the new subsidy more frequently than the uninsured.

<sup>8</sup> Some states that have adopted similar rules for basic SCHIP eligibility allow exceptions to the waiting period for involuntary loss of coverage, either because the employer dropped benefits or because the worker changed to a job without ESI. Some of these states treat a change of employment from a job with ESI to one without ESI as an involuntary coverage loss; others treat this as a voluntary change unless the worker actually lost the earlier job. These exceptions, however, may encourage workers to seek employment that does not offer ESI. At the same time, they leave people who retain their ESI permanently disadvantaged.

<sup>9</sup> Author's analysis of the 1996 MEPS; the figures exclude Medicare beneficiaries with employer coverage and people for whom only part-year data were available.

<sup>10</sup> In this example, the cost to the employer to hold workers fully harmless, after payroll and income taxes, would be about \$70 for workers in the 15 percent bracket, leaving a savings of \$30. Only if the ESI subsidy were less than 30 percent of the employee share would it be unprofitable for employers to tinker with contributions and wages in this way.

<sup>11</sup> States are allowed to use a lower percentage if they can justify it; the few ESI assistance programs approved to date all have a 50 percent minimum.

<sup>12</sup> This is true of a program offering publicly financed coverage to adults. It is not necessarily true under SCHIP, where the public program covers only children, while an ESI subsidy may represent a contribution to the cost of coverage for the entire family (because the employer will not allow enrollment of the children alone). As the employer contribution to family coverage declines, there is some point at which it becomes cheaper to cover just the children directly.

<sup>13</sup> Here again, the likelihood of this response depends in part on the relative attractiveness or generosity of the public program. However, it seems probable that many low-income workers who could be assured of at least some basic level of publicly financed, virtually free coverage would prefer to shift if they could then receive some portion of the employer's savings in the form of higher wages.

<sup>14</sup> Zelenak, *A Health Insurance Tax Credit for Uninsured Workers*, paper prepared for this project.

<sup>15</sup> The non-group credit is reduced by \$150 per \$1,000 in income above a phase-out point that varies by family size. The credit reaches zero for a single person with income of \$30,200, for a couple with income of \$48,600, or for a family of six with income of almost \$66,000.

<sup>16</sup> KFF-HRET, 1999. In firms where over 35% of workers earned less than \$20,000 per year in 1999, the average employer contribution was 82% for single coverage and 60% for family coverage.

<sup>17</sup> Some employers vary contribution by age.

<sup>18</sup> At the same time, the pool of non-group purchasers would be improved by a potential influx of low-risk enrollees. In the absence of non-group insurance-rate regulation, however, this would do nothing to lower prices for higher-risk purchasers. Insurers in a competitive market would instead have an incentive to offer low-risk purchasers the best possible benefits that could be furnished for the credit amount, while offering high-risk applicants fewer benefits at a higher price.

<sup>19</sup> The incentives for this are greater in large experience-rated or self-insured employer plans. Because of small-group market reforms in most states, the costs of high-risk employees are spread across the entire pool, and an individual employer might not see savings from shifting one employee.

<sup>20</sup> Insurers selling to employer groups would gain; these are not necessarily the same insurers.

<sup>21</sup> There would be no incremental cost if a worker whose employer offered only a choice of single or family coverage enrolled the children as well as a spouse in the family plan. There would be a cost if a single parent enrolled children under family coverage, or if a couple could have obtained a two-adult rate. On balance, given that employers must be covering at least half the cost (really about a third after the tax subsidy), the ESIC is probably less costly for the federal government.

<sup>22</sup> HCFA has indicated that it might consider allowing this use of SCHIP funds on a demonstration basis. Letter to state officials from Timothy Westmoreland, Director, Center for Medicaid and State Operations, July 31, 2000.

<sup>23</sup> Plans that weren't really "health insurance," such as separate dental or vision plans or plans providing fixed hospital indemnity payments, should be excluded. HIPAA's definition of "excepted

<sup>24</sup> In practice, states must do both, because there are almost no employer plans whose copayments or other cost sharing will not in some cases exceed the SCHIP maximums.

<sup>25</sup> Assessing benefits would be relatively easy if all employers bought one of a few standardized plans from major carriers. But many employer plans are self-insured, and there may be considerable variation even in the insured plans different firms buy from a single carrier.

<sup>26</sup> For example, someone earning \$20,000 would receive a non-group credit of \$1,535 and would have to pay \$465 for a \$2,000 non-group policy. A worker with the same income receiving the ESIC would pay nothing for a \$2,000 employer plan if the employer's contribution were at least the minimum 70 percent.

<sup>27</sup> For example, a "personal responsibility amount" (PRA) would be established for each worker. This would be the amount a worker at the same wage level receiving the non-group credit would have to contribute toward a \$2,000 non-group plan. The ESIC could equal the actual employee contribution minus the PRA. This smaller ESIC would be less costly, but it would also be less likely to encourage participation by workers currently declining ESI. It would also create the very high marginal tax rate that Zelenak notes as a concern with the non-group credit.

<sup>28</sup> This could occur if the employer plan is very generous, if the employer is in a high-cost area, or if the group has many older or sicker workers. For couples, an employer plan could also be high-cost if it offered only single and family rates instead of a separate two-adult rate.

<sup>29</sup> The 80 percent factor is arbitrary. A typical worker's contribution for single coverage is 20 percent. The employer's contribution is four times the worker's, and the tax subsidy (at about 30 percent of the employer's contribution) is 1.2 times the worker's contribution. However, using this factor to reduce the maximum ESIC heavily penalizes workers contributing a high share toward a high-cost plan. The lower factor protects these workers while overpaying some workers making lower contributions.

<sup>30</sup> Author's calculation, based on the March 1999 supplement to the Current Population Survey.

<sup>31</sup> Self-insured employers could report the nominal "premium" used in computing charges for participants in COBRA continuation coverage.

<sup>32</sup> See, for example, Mark Pauly, *Extending Health Insurance through Insurance Credits*, Washington, D.C., Henry J. Kaiser Family Foundation, October 1999.

<sup>33</sup> The current exclusion of employer contributions from taxable income reduces the cost of coverage for a worker in the 15 percent bracket by about 28 cents for each dollar spent, while the refundable non-group credit reduces the cost by a dollar. An ESIC would have to be much larger than the worker's actual ESI contribution to make the worker as well off retaining the ESI as dropping it. While the cost might still be less than the cost of the non-group credit, a credit larger than the apparent amount spent by the worker would obviously be a difficult political sell.

<sup>34</sup> The assistance may cover family members who are not eligible for the public program (for example, parents of SCHIP-eligible children). However, the total payment may not be more than would otherwise have been spent for the eligible family members.

<sup>35</sup> OBRA 1990 required states to provide premium assistance when it was cost-effective to do so; BBA 1997 made assistance optional.

<sup>36</sup> Florida's proposal to include ESI assistance in its SCHIP plan was rejected in late 1999.

<sup>37</sup> Wisconsin reportedly had enrolled a single family as of August 2000.

<sup>38</sup> Whether this should be permitted has not been resolved by the administering agencies, DOL and DHHS.

<sup>39</sup> Section 89 penalized plans under which highly compensated employees received more generous benefits than lower-income ones even if the same benefits were offered to the lower-income workers at the same cost.

<sup>40</sup> KFF-HRET finds that 25 percent of workers had a choice of plans in 1999, while 50 percent had access to some form of flexible benefit arrangement.

<sup>41</sup> In 1995, only 12 percent of employers with multiple plans did not provide a higher contribution for the more costly plans. Kelly A. Hunt et al., "Paying More Twice: When Employers Subsidize *Health Affairs* 16 (November/December 1997): 150–156.

<sup>42</sup> This is part of the rules for determining "modified adjusted gross income" (MAGI) for the purpose of the earned income credit (EIC).

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*#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.

*#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.