Incremental Coverage Expansion Options:

Detailed Table Summaries to Accompany Option Papers Commissioned by The Commonwealth Fund Task Force on the Future of Health Insurance

Description of Approach, Key Features, Target Populations,
and Estimates of Likely Coverage and Costs

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CONTENTS

OVERVIEW OF DETAILED SUMMARY TABLES

To inform the debate on incremental coverage expansions, The Commonwealth Fund Task Force on the Future of Health Insurance commissioned nine authors to explore new options for expanding coverage that went beyond more traditional expansions through Medicaid. These papers explore a variety of approaches to incremental coverage expansion including strategies that would subsidize the purchase of insurance through new tax credits, would build on employer coverage bases and approaches that would open up new group options for coverage to those currently uninsured.

The following tables are designed to accompany the authored papers and policy proposals. Table 1 provides an overview of the set of commissioned policy option papers. Tables 2 and 3 provide detailed summaries of the proposals and estimate likely coverage and costs.

The comparison of designs and key features reflects the authors' proposals. Likely coverage rates and costs were prepared by a team of researchers led by Sherry Glied at Columbia University. The modeling effort used a common set of assumptions about poverty rates and family structure based on recent national surveys to estimate the eligible population while cost figures drew on health insurance premium estimates provided by Actuarial Research Consulting, Inc.[1] Participation rates for the first two proposals in Table 1 resulted directly from the health insurance tax credit model developed by Jonathan Gruber of MIT.[2] Various extensions and modifications on Jonathan Gruber's model yielded take-up rates for the other plans.

The detailed summary tables describe each approach and target population, key features, and estimate likely coverage and costs as well as participation rates. The coverage estimates include estimates of the net reduction in the numbers uninsured (net expansion of coverage) as well as estimates of currently insured populations that would qualify for the expansion. Costs estimates include likely total costs and costs per newly insured person.

The policy proposals evaluated in the Workable Solutions project represent a variety of options available for reducing the number of uninsured. These plans range from the Zelenak basic tax credit for low-income individuals to the Meyer and Wicks employer tax credit approach to the Short, Shea, and Powell plan for the pre-Medicare population. We summarize each plan's components and our findings on the costs and consequences of each in the attached side-by-side. As illustrated in the detailed summaries (Table 2), the
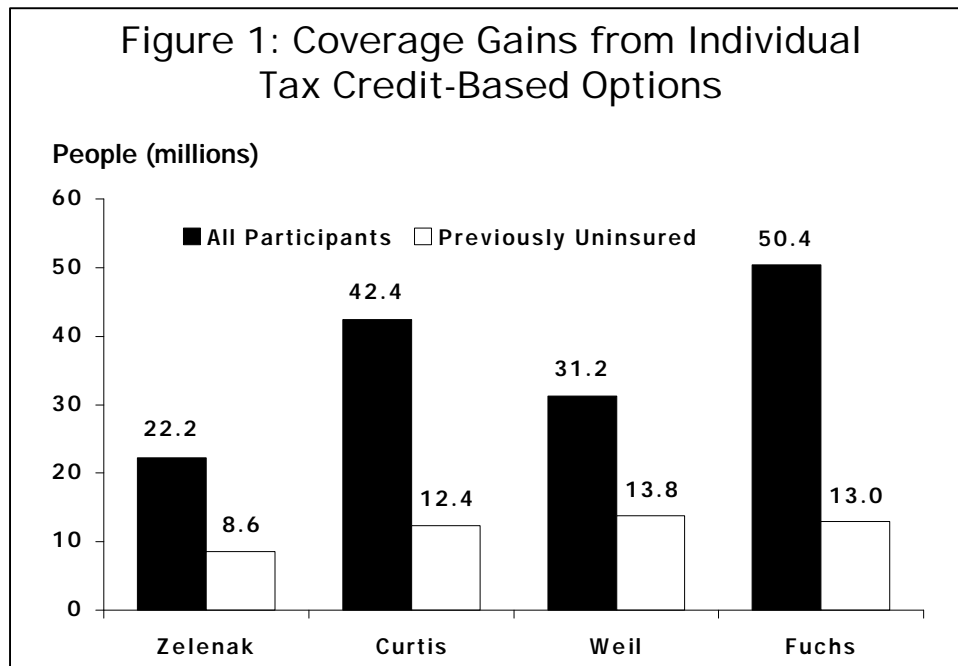
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[1] The modeling effort used population and coverage estimates based on the March 1999 and February 1997 Current Population Surveys, the National Health Insurance Survey and MEPS.
[2] Gruber, Jonathan. "Tax Subsidies for Health Insurance: Evaluating the Costs and Benefits," prepared for the Kaiser Family Foundation, January 2000.

five papers that consider possible individual tax credits or individual subsidies, used a common set of assumptions regarding the basic subsidy range and amounts.

Coverage and Cost Comparisons

Figure 1 shows the differences in take-up across the four options that build on individual tax credits (the proposals by Zelenak; Curtis, Neuschler, and Forland; Weil; and Fuchs). These options provide health insurance coverage to 9 to 14 million people who would otherwise be uninsured. They also provide financial assistance toward the purchase of coverage to 13 to 21 million low-income people who currently purchase coverage at substantial costs. Finally, the options that allow firms to join purchasing pools (Curtis, Neuschler, and Forland; and Fuchs) enroll an additional 15 to 21 million people (from 1 to 2 million of whom were previously uninsured) who do not receive tax credits into new, lower-cost purchasing venues. In the simulation model used here, people leave existing coverage for new insurance only if they would experience a substantial reduction in out-of-pocket costs by doing so. Given the subsidy design described here, this move from unsubsidized to subsidized coverage is only likely to happen for those with both low incomes and high current out-of-pocket costs.

Figure 1: Coverage Gains from Individual Tax Credit-Based Options

People (millions)

|	All Participants	Previously Uninsured
Zelenak	22.2	8.6
Curtis	42.4	12.4
Weil	31.2	13.8
Fuchs	50.4	13.0

The Curtis, Neuschler, and Forland; Weil; and Fuchs proposals each incorporate a new venue for purchasing coverage and all have somewhat higher take-up than the basic tax credit. In our estimates, adding a venue has a modest effect (5%) on the price of health insurance and this, in turn, increases take-up slightly. A more important feature of the venues in each proposal is that they enable families with CHIP-eligible children to obtain coverage as a family unit. This feature substantially increases take-up, especially among the

lowest-income subsidy recipients. These recipients are also those most likely to be currently uninsured.

The final feature that separates these proposals is their treatment of high-risk people. The Zelenak proposal envisions a standard, experience-rated individual insurance market, so low-risk people will face low prices but high-risk people may not be able to afford coverage. The Curtis, Neuschler, and Forland proposal creates a single, community-rated insurance market, raising prices for low-risk people and lowering them for high-risk people. In the Weil proposal, subsidy recipients may choose between the individual insurance market and the CHIP pool. We expect that the lowest-risk recipients will choose the individual insurance market, while the CHIP pool will act, in effect, as a high-risk pool for the highest-risk recipients. This means that low-risk purchasers will pay lower rates, while high-risk purchasers will be subsidized separately through the CHIP pool. This separation leads to increased take-up rates. Similarly, in the Fuchs proposal, the separate reinsurance market will provide an alternative source of subsidies for high-risk purchasers. Reinsurance lowers premiums in the plan, raising take-up rates both among those currently uninsured and among those who currently have costly coverage.

These differences in take-up rates translate into differences in the cost per newly insured person (Figure 2). The Weil proposal is a little less costly than the others because CHIP, which has established panels of relatively low-cost providers, can offer care to high-risk people at lower cost than we expect can be obtained in the individual market. The Fuchs proposal is a little more costly than might be expected because the reinsurance cost must also be included in the cost of the proposal.

Figure 2: Costs per Newly Insured Person from Individual Tax Credit-Based Options
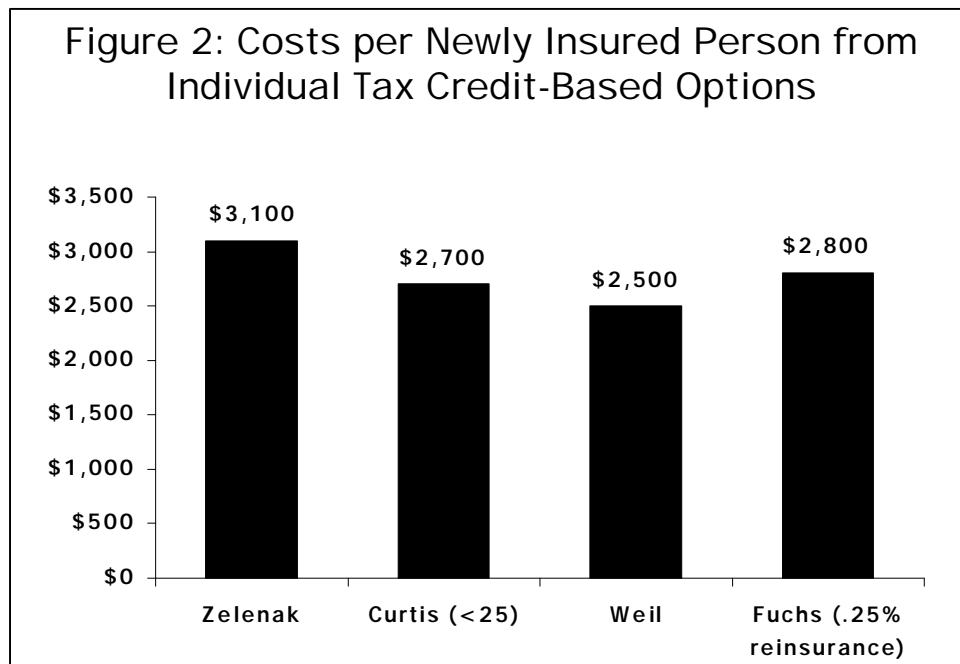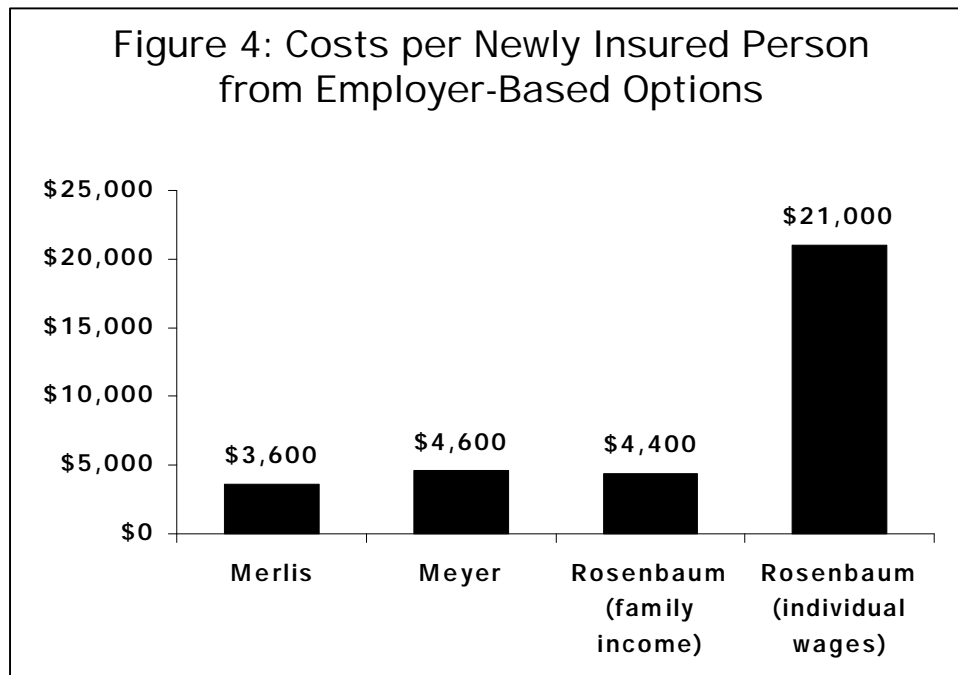
The next set of options—those by Merlis; Meyer and Wicks; and Rosenbaum, Borzi, and Smith—build on the employer base (Figure 3). The Merlis proposal would permit the tax credit described by Zelenak to be used toward the purchase of employer-based coverage. This proposal would provide coverage to about 3 million more previously uninsured people than the Zelenak proposal, for a total of nearly 12 million previously uninsured. It would also provide subsidies to 46 million additional low-income workers, covering a portion of their share of employer-sponsored insurance costs. Proposals to help employees buy employer-sponsored coverage tend to be more costly per newly uninsured person than individual-based proposals. This result is a consequence of the fact that most employees who are offered coverage already take it up (though many face very high costs to do so). The higher take-up rate among the previously insured in this proposal generates a higher cost per newly insured person.

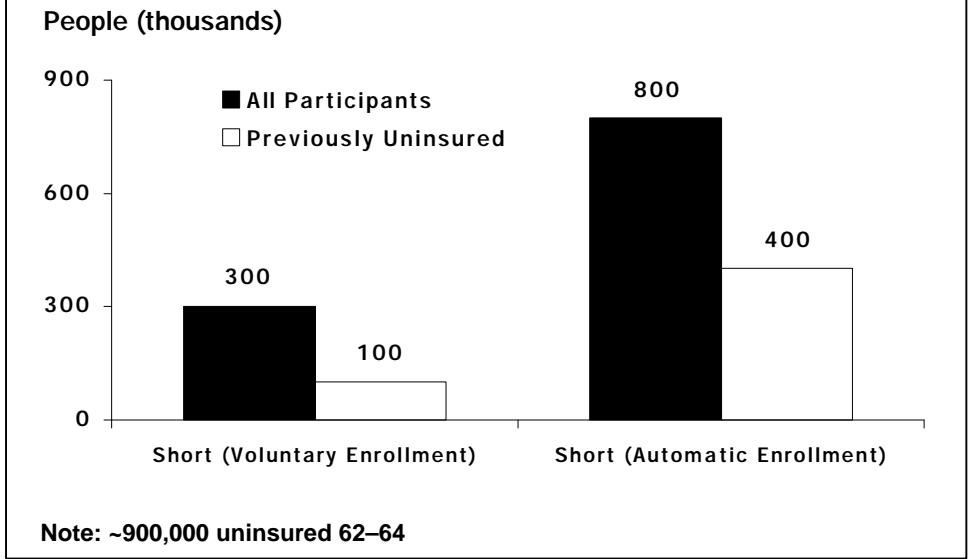Figure 3: Coverage Gains from Employer-Based Options
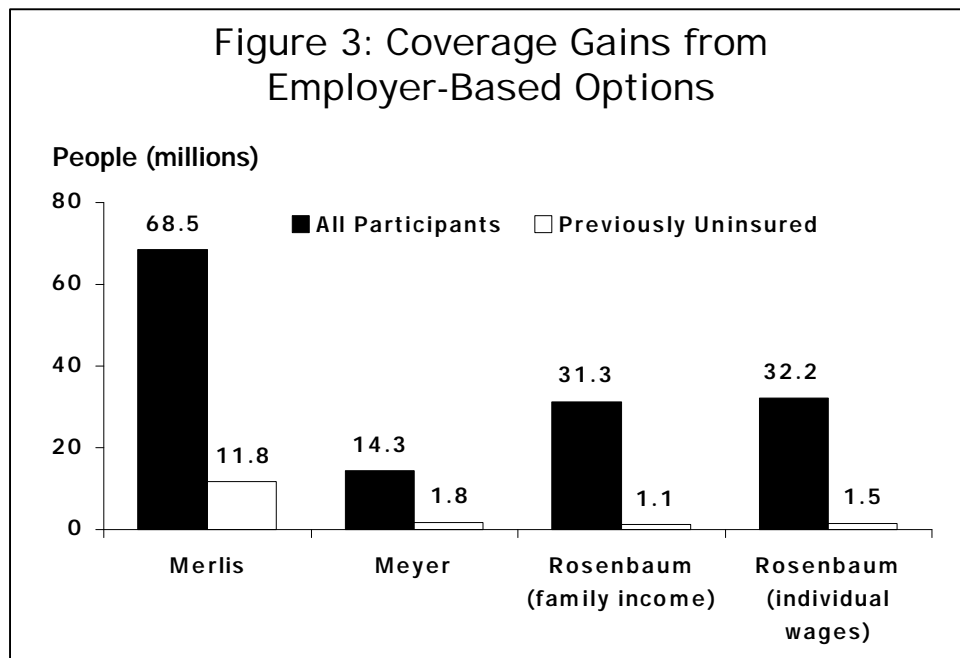
The Meyer and Wicks and Rosenbaum, Borzi, and Smith proposals both encourage employers to offer coverage. They would cover from 1 to 2 million of those previously uninsured and provide subsidies to 3 to 20 million of those currently covered. The Rosenbaum, Borzi, and Smith proposal would also allow firms to participate in CHIP even if they and their employees were not eligible for subsidies. Through this feature, from 12 to 28 million people, about 1 million of whom were previously uninsured, would obtain less costly CHIP coverage. At the firm level, the subsidy structure for the Meyer and Wicks proposal is more generous than in the Rosenbaum, Borzi, Smith proposal, so the former proposal generates more take-up among the previously uninsured than does the latter.

The difference in cost between the two Rosenbaum, Borzi, and Smith estimates reflects the difference between using hourly wages or annual incomes in computing subsidies (Figure 4). Since many workers paid low hourly wages live in households that also include a highly paid worker, and since the family income of two low-paid workers can still be relatively high, programs that use wages, rather than incomes, to target subsidies will tend to be more costly.

Figure 4: Costs per Newly Insured Person from Employer-Based Options

Option	Cost
Merlis	$3,600
Meyer	$4,600
Rosenbaum (family income)	$4,400
Rosenbaum (individual wages)	$21,000

The final set of estimates in the table is for the proposal by Short, Shea, and Powell targeting the pre-Medicare population (Figure 5). We estimated only the voucher component of this proposal. The difference in take-up between the two sets of estimates for this proposal reflects the benefit of automatic enrollment. Since the Social Security Administration (SSA) collects information about lifetime incomes, it could send vouchers to low lifetime income families automatically. If the SSA behaved in this way, take-up would be very high in this population. Otherwise, take-up would require individual enrollment, as with the other proposals described here. Under automatic enrollment, this proposal would cover nearly half of the 900,000 near-elderly who lack coverage and nearly all of those eligible for the voucher. Note that not all currently uninsured near-elderly people have had low lifetime incomes, while many of those with low lifetime incomes currently do hold health insurance coverage. Automatic enrollment lowers the cost per newly insured person in this proposal, because it increases take-up among the currently uninsured more than among those who currently have insurance.

Figure 5: Coverage Gains from Pre-Medicare Targeted Option

People (thousands)

- ■ All Participants
- □ Previously Uninsured

	Short (Voluntary Enrollment)	Short (Automatic Enrollment)
All Participants	300	800
Previously Uninsured	100	400

Note: ~900,000 uninsured 62–64

The Appendix provides a general discussion of key issues underlying the estimates as well as more details of our methodology.

Table 1
Proposal Authors and Descriptions

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.
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 tradeoff.
Building New Bases for Expanded Coverage: Public Program and Employer-Based Options	
Private Purchasing Pools to Harness Individual Tax Credits for Consumers Richard E. Curtis, Edward Neuschler, and Rafe Forland	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.
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.

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.
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 subsidy to help employees pay their share of premium costs in employer-sponsored plans.
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 subsidies) to employers of low-wage workers as incentives to offer coverage.
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.
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 spells uninsured.

* This is a companion piece to the Zelenak paper. For details, see the Swartz paper.

Table 2: Detailed Summary of Proposals That Include Individual Subsidies or Tax Credits

Author(s)	Zelenak	Curtis, Neuschler, and Forland	Weil	Fuchs
Title	*A Health Insurance Tax Credit for Uninsured Workers*	*Private Purchasing Pools to Harness Individual Tax Credits for Consumers*	*Buying into Public Coverage: Expanding Access by Permitting Families to Use Tax Credits to Buy into Medicaid or CHIP Programs*	*Increasing Health Insurance Coverage Through an Extended Federal Employees Health Benefits Program*

Program Summary

Target Population	Low-income uninsured without offer of ESI	Low-income workers without ESI offer or in small firms (<50 employees)	Uninsured whose children are CHIP or Medicaid eligible	Low-income workers without ESI offer or in small firms (<10 employees)
Subsidy Structure	• Tax Credit of $2,000 (individual) $4,000 (family) • possibly age- and sex-adjusted	• Same Tax Credit • *ONLY* available if used with recognized purchasing pool	• Same Tax Credit • available for CHIP or Medicaid *in addition to* individual insurance market	• Same Tax Credit • *ONLY* available if used with extended-FEHBP

Author(s)	Zelenak	Curtis, Neuschler, and Forland	Weil	Fuchs
Administrative Structure	• Partial (but substantial) advance payment • Determination by IRS • Reconciliation at end of year by IRS • IRS pays insurer • Use of existing non-group market or COBRA	• Competing purchasing pools within state • Pools available to anyone in the individual market or any employees of small firms • Pools offer choice among competing plans • Federal rules determine pool qualifications • Pool would also coordinate with employers for payroll deduction • Pool would coordinate to allow purchase of Medicaid and CHIP plans	• States determine plans offered and mechanisms to collect additional premium payments if necessary • Start of year determination of tax credit level to be binding—undecided who will bear risk	• Extended FEHBP system available to anyone in the individual market and employees of small firms.

Author(s)	Zelenak	Curtis, Neuschler, and Forland	Weil	Fuchs
Evaluation				
Cost of Coverage (income, health status, geographic variation)	• Entire tax credit below FPL, sufficient on average • No geographic adjustment • No health status adjustment	• At least one plan available at premium equal to tax credit • Health status rating not allowed for fully subsidized population • Age rating permitted	• Subsidy may not be enough to cover the plans • No adjustment for high-cost regions	• Subsidy may not be enough to cover the plans • No adjustment for high-cost regions • Health status rating not allowed
Non-Price Factors (transitions in coverage, admin. Complexity, marketing, family fragmentation, stigma)	• Eligibility is month-by-month • Status changes reported to IRS who makes determination	• In principle, family fragmentation reduced by allowing coordination with Medicaid/CHIP	• Family fragmentation reduced for those with CHIP and Medicaid eligible children • Much greater continuity of coverage for those with unstable income and job situations • Potential problems moving across states	• Administratively complex for Federal Government

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Author(s)	Zelenak	Curtis, Neuschler, and Forland	Weil	Fuchs
Quality of Coverage	• No regulation could result in poor quality plans appearing on the market	• Depends on regulation or quality of pool oversight • Requiring a plan available for tax credit may hurt quality in high-cost regions	• Same as Medicaid/CHIP	• Pre-existing conditions exclusions allowed in accordance with HIPAA Rules • High quality, at least where FEHBP has some size • Plans will be the same as FEHBP, although premiums may differ
Effects on Non-Subsidized Groups	• Employers may drop coverage • Non-group market could become cheaper due to influx of lower risk individuals		• May reduce stigma of Medicaid plans	• Some insurers may drop out of FEHBP
Program Cost (targeting, state maintenance of effort)	• Some crowd-out due to employers drops, but mitigated in part by tax subsidy and group-non-group price differential • Medicaid/CHIP crowd-out limited because of greater Medicaid/CHIP benefits and coverage of children		• States likely to try to shift people into Federal tax credit program from Medicaid	

Author(s)	Zelenak	Curtis, Neuschler, and Forland	Weil	Fuchs
Phase-Out	• 15% implicit income tax starting at 200% FPL until no credit	• Same phase-out • No group size phase-out	• Same phase-out	• Same phase-out
Costs and Coverage				
Previously Uninsured Potentially Eligible*	38.6 million	38.6 million	38.6 million	38.6 million
Subsidized Take-Up by the Previously Uninsured	8.6 million (A) 8.4 million (B)	11.0 million (A) 11.0 million (B)	13.8 million	11.3 million (A) 11.5 million (B)
Estimated Total Subsidized Take-Up	23 million (A) 23 million (B)	28 million (A) 28 million (B)	31 million	30 million (A) 32 million (B)
Total Cost of Subsidies	$25 billion (A) $26 billion (B)	$30 billion (A) $30 billion (B)	$34 billion	$32 billion (A) $33 billion (B)
Net Cost per Newly Insured (net of newly uninsured)	$3,100 (A) $3,300 (B)	$2,700 (A) $2,800 (B)	$2,500	$2,800 (A) $3,000 (B)
Average Subsidy per Uninsured in Target Population	$1,409 (A)	$1,409 (A and B)	$1,409	$1,409 (A and B)
Estimated Unsubsidized Take-Up	N/A	15 million (A) 15 million (B)	N/A	21 million (A) 21 million (B)

Author(s)	Zelenak	Curtis, Neuschler, and Forland	Weil	Fuchs
Unsubsidized Take-Up by the Previously Uninsured	N/A	1.3 million (A) 1.4 million (A)	N/A	1.7 million (A) 2.3 million (A)
Key Modeling Assumptions Relevant to This Proposal	• (A) Non age-/ sex-adjusted tax credits • (B) Age-/sex-adjusted tax credits	• (A) Eligibility excludes workers in firms w/ >25 employees that offer ESI • (B) Eligibility excludes workers in firms with >100 employees that offer ESI • Pool premiums 5% less than nongroup • No health rating • Greater take-up among families with members in Medicaid/CHIP • The Medicaid/ CHIP factor increases take-up by approx. 18% • The existence of pools as an alternative to nongroup coverage reduces the number of newly nongroup	• Medicaid/CHIP premiums 5% less than nongroup • No health rating • Greater take-up among families with members in Medicaid/CHIP • The existence of buy-in option as an alternative to nongroup coverage reduces the number of newly nongroup	• (A) 0.25% ceded to reinsurance pool E-FEHBP premiums 9% less than nongroup • (B) 1% ceded to reinsurance pool E-FEHBP premiums 19% less than nongroup • No age, sex, or health rating • Greater take-up among families with members in Medicaid/CHIP • Greater take-up among residents of Washington, D.C. • The existence of E-FEHBP as an alternative to nongroup coverage reduces the number of newly nongroup

* Under certain circumstances, the currently insured would also be eligible for the expansion proposals. For the five proposals that provide tax credits for those with incomes up to 300% of poverty, potentially 145 million people (including insured and uninsured) would be income-eligible.

Table 3: Detailed Summary of Employer-Based and Special Population Proposals

Author(s)	Merlis	Meyer and Wicks	Rosenbaum, Borzi, and Smith	Short, Shea, and Powell	Gruber
Title	*Public Subsidies for Required Employee Contributions Toward Employer-Sponsored Insurance*	*A Federal Tax Credit to Encourage Employers to Offer Health Coverage*	*Allowing Small Businesses and the Self-Employed to Buy Health Care Coverage Through Public Programs*	*A Workable Solution for the Pre-Medicare Population*	*Transitional Subsidies for Health Insurance Coverage*
Program Summary					
Target Population	Low-income uninsured and uninsured workers with offer of ESI	Employees in low-wage firms Self-employed if state law includes groups of one in small groups	Employees of small firms (<25 employees) and the self-employed	62–64 year olds, particularly early retirees and poorer individuals	Job losers and leavers
Subsidy Structure	• Same Tax Credit • ESIC = lesser of employee contribution and tax credit	• Tax Credit is for *firms* with average wage rates <= $10/hour • Credit level tied to price of standard plan • Credits distinct for individual and family coverage • Employers must contribute 50% of standard plan premium	• Full employee share of (base) premium cost and 25% employer share for <100% FPL • 100%–150% FPL subsidize 75% of base premium • 150% FPL-max income subsidize 50% base premium • Alternative based on hourly wage	• Voucher for 62–64-year-olds with *lifetime income* <= 200% FPL • Lifetime income is average of prior 40 years' income • IRA tax benefits or payroll deductions available to others	• Income-related forgiveness of COBRA Loans • Full Forgiveness <=FPL • Full repayment >=300% FPL

Author(s)	Merlis	Meyer and Wicks	Rosenbaum, Borzi, and Smith	Short, Shea, and Powell	Gruber
Administrative Structure	• Same system plus ESI contribution • ESIC available if employer contributes 70% of individual or 50% of family	• Credits available in installments • Refundable tax credit • Administered by IRS • No restrictions on plans offered beyond usual ESI	• Allow small firms and self-employed to use CHIP plans • State would be responsible for collection of premiums from employers and employees • States would subsidize premiums to limit premium cost growth	• All 62–64-year-olds can buy into Medicare • Subsidized voucher available for Medicare or other insurance • Voucher of higher amount if used for Medicare • Pre-Medicare IRA available from age 50 for use after age 62	• Expand COBRA coverage to 36 months • COBRA qualifications extended to one-year's prior employment • Federal Loans available for COBRA • New COBRA Loan Organization would pay employer premiums, tally debts and arrange repayment • Employer tax credit for COBRA costs above 2%

Author(s)	Merlis	Meyer and Wicks	Rosenbaum, Borzi, and Smith	Short, Shea, and Powell	Gruber
Evaluation					
Cost of Coverage (income, health status, geographic variation)	• No adjustment for high-cost regions • High-risk firms will have high-cost premiums • Some firms with ESI ineligible due to low employer contributions	• No geographic adjustment in tax credit • Underwriting could make premiums unaffordable for high-risk firms	• No problem for those with full subsidy, regardless of location or health status	• Full Medicare buy-in for <100% FPL • Affordability problems for the myopic high-income • Affordability for poorer health status • Medicare rating not adjusted for geographic variation	• Affordable for low-income job losers and leavers, irrespective of health status and region
Non-Price Factors (transitions in coverage, admin. complexity, marketing, family fragmentation, stigma)	• Employer administrative burden very similar to existing benefits and tax requirements • Payroll deductibility easy for employees • Fragmentation reduced relative to simple tax credit	• Credit available in installment, easing cash flow difficulties • Employer administrative burden not very different from existing tax and benefits burden • Transitions and fragmentation same as for general ESI	• Workplace center lowers burden for employees but can create substantial employer burden • Reduces family fragmentation • 12-month enrollment period reduces transition problems	• Smooth transitions with both ESI and Medicare • Avoids family fragmentation • Voucher simple to use for Medicare (unclear for other insurance)	• Smooth transitions • Modest additional complexity for employers and workers

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Author(s)	Merlis	Meyer and Wicks	Rosenbaum, Borzi, and Smith	Short, Shea, and Powell	Gruber
Quality of Coverage	• Additional oversight of ESI plans • Potential problems with poor ESI plans	• Same as ESI	• Same oversight of quality as CHIP	• Good Medicare quality and political pressure to maintain quality	• High, same as ESI
Effects on Non-Subsidized Groups	• Employers may lower contributions	• Gives firms incentives to keep wages down and compensate in non-wage forms		• Improves risk profile of non-retiree employees if retiree coverage dropped or reduced • No disincentives to work	• Reductions in job lock • Reduces adverse selection for COBRA pool
Program Cost (targeting, state maintenance of effort)	• Reduces employer dropping relative to tax credit • Reduces CHIP/Medicaid burden on states	• Some crowd-out of existing ESI plans	• Some crowd-out of existing ESI plans	• Employers likely to reduce contributions but coverage itself likely to be maintained • States have incentive to reduce Medicaid	• Some crowd-out of low-income job losers already willing to pay for COBRA, but a small group, probably worthy of subsidy
Phase-Out	• Same phase-out	• Implicit tax for firms due to credit phase-out	• Sizeable implicit tax from 100% FPL to max income • No firm size phase-out	• Use of lifetime income reduces implicit tax rate	• Sizeable implicit tax on earnings after returning to job between 100% and 300% FPL

Author(s)	Merlis	Meyer and Wicks	Rosenbaum, Borzi, and Smith	Short, Shea, and Powell	Gruber
Costs and Coverage					
Previously Uninsured Potentially Eligible*	38.6 million	7.7 million	8.0 million (A) 9.3 million (B)	.499 million	
Subsidized Take-Up by the Previously Uninsured	11.8 million	1.8 million	0.2 million (A) 0.6 million (B)	0.04 million (A) 0.3 million (B)	
Estimated Total Subsidized Take-Up	69 million	14 million	3 million (A) 20 million (B)	0.3 million (A) 0.8 million (B)	
Total Cost of Subsidies	$41 billion	$9 billion	$1 billion (A) $13 billion (B)	$ 0.5 billion (A) $2 billion (B)	
Net Cost per Newly Insured (net of newly uninsured)	$3,600	$4,600	$4,400 (A) $21,000 (B)	$13,600 (A) $4,900 (B)	
Average Subsidy per Uninsured in Target Population	$1,409	$950	$636 (A) $743 (B)	$2,242 (A and B)	
Estimated Unsubsidized Take-Up	N/A	N/A	28 million (A) 12 million (B)	.02 million (A) .02 million (B)	
Unsubsidized Take-Up by the Previously Uninsured	N/A	N/A	0.9 million (A) 0.8 million (B)	0.01 million (A) 0.01 million (A)	

Author(s)	Merlis	Meyer and Wicks	Rosenbaum, Borzi, and Smith	Short, Shea, and Powell	Gruber
Key Modeling Assumptions Relevant to This Proposal		• All eligible firms currently offering ESI accept the tax-credit • Anyone currently insured through an employer automatically takes up. This applies to family members as well. • The self-employed are excluded from eligibility • Final results depend on both firma and individual take-up	• (A) Eligibility is based on family income • (B) Eligibility is based on individual hourly wages • ECHIP premiums are 5% less than nongroup • No health rating • All eligible firms currently offering ESI accept the tax-credit • Anyone currently insured through an employer automatically takes up. This applies to family members as well. • Final results depend on both firm and individual take-up	• (A) No automatic enrollment • (B) Automatic enrollment by SSA • Age-/sex-adjusted Medicare premiums are $3,798 for men and $3,277 for women • The eligible population is too small to affect firm behavior in response to this program	

* Under certain circumstances, the currently insured would also be eligible for the expansion proposals. Under the Rosenbaum, Borzi, and Smith proposal, 17 to 38 million people would be income-eligible; under the Meyer and Wicks proposal, 27 million; and under the Short, Shea, and Powell proposal, 1.4 million.

APPENDIX

This discussion describes some of the principal issues that emerge as you compare the eligibility, cost, and take-up numbers provided in the side-by-side and provides additional details on modeling assumptions.

Principal Issues

- Community health rating in the plans that would provide an alternative venue to the nongroup market in which people may purchase health insurance benefits the least healthy and hurts the most healthy. Since the nongroup market often underwrites for health status, those in poor health would face significantly higher premiums in the private insurance market than in a community rated program. Similarly, very healthy individuals may obtain cheaper premiums in a nongroup market which rewards good health. Since there are more healthy people than sick people in the uninsured population, the numbers of newly insured will generally be lower in community-rated proposals (and proposals with age-/sex-adjusted credits) than in proposals that permit underwriting. Similarly, in our model, fewer firms will drop coverage under community-rated proposals. The average cost (and value) of coverage for those covered will be greater, however, under community-rated proposals.

- Crowd-out is a problem in all of the proposals. Given the practical difficulties in enforcing anti-crowd-out measures such as denying tax credits to families with an offer of employer-sponsored insurance (ESI), we have ignored all such provisions in our model. Participation by those with ESI increases when the cost of coverage through a new plan is lower than the cost of ESI coverage. The two sets of estimates for the Fuchs plan show this problem clearly. Ceding 1 percent of claims, rather than 0.25 percent of claims, to the reinsurance pool, reduces the price of coverage substantially. This decline in prices increases take-up among those with ESI by more than it increases take-up among those currently uninsured.

- The two sets of estimates of the Rosenbaum, Borzi, and Smith proposal highlight some of the differences between basing tax credit eligibility on family income versus individual wages. Equal shares of the population are eligible to buy into ECHIP without a subsidy, but eligibility for a tax credit (and thus take-up) expands considerably with the wage criterion. This is most striking in the case of those with ESI. Consequently, basing eligibility on wages is significantly more

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costly than basing it on incomes both in absolute terms and in terms of cost per newly insured.

- As the Curtis, Neuschler, and Forland, Fuchs, and Weil plans show, similar program structures combined with different purchasing venues makes relatively little difference in terms of either overall take-up, total cost, or cost per newly insured.

- Though structurally similar, the fundamental differences between these plans should be noted: The Curtis, Neuschler, and Forland and Weil plans use community health-rated (pool or Medicaid/CHIP) premiums whose bases are 5 percent less than nongroup; The Fuchs proposal uses community age-, sex-, and health-rated (E-FEHBP) premiums which are rooted as nongroup base premiums discounted 9 percent and 19 percent, depending on assumptions about the reinsurance pool. Unlike the others, the Weil proposal helps both high- and low-risk individuals by offering the freedom to use tax credits in either the nongroup market or Medicaid/CHIP. The requirement of the purchasing pool and E-FEHBP programs that tax credits be used only in pools or E-FEHBP, respectively, tends to prevent low-risk individuals from taking up since they may find health-rated nongroup premiums more attractive than those in community-rated pools or E-FEHBP.

- Due to their potential for cooperation with existing public health programs, the Curtis, Neuschler, and Forland, Fuchs, and Weil plans share one important feature: a specific incentive for families with members eligible for Medicaid or CHIP to take up. In our modeling, this factor substantially increases take-up among the uninsured. For example, take-up increases by 22 percent in the Curtis, Neuschler, and Forland proposal as a consequence of this factor.

- The cost per newly insured person under plans that target those who are employed and permit job-based coverage (Rosenbaum, Borzi, and Smith; Meyer and Wicks; and Merlis) is greater than under plans that permit individual coverage only. The reason for this difference is that among those in a given income bracket, employed people are much more likely to already hold private health insurance than are those without a connection to the labor market. Thus, plans that permit employer-sponsored coverage have higher crowd-out than plans that permit individual coverage only.

- While we assume for plans that interact with Medicaid/CHIP that people with family members eligible for these public programs are more likely to take up, it is important to note that cost estimates do not reflect the increased cost resulting from new Medicaid/CHIP enrollment.

Basic Modeling Decisions

Jonathan Gruber, using his model for the Kaiser Commission (extensively documented), provided estimates for the Zelenak and Merlis proposals. The assumptions used in that model are described in his paper. We built a model that we calibrated to Gruber's estimates for these proposals, and then used that model to estimate the other proposals in the set. Below, we discuss the modeling decisions we made along the way that apply generally to all proposals. This is followed by a more detailed discussion of important assumptions specific to each plan.

Family size

- People are grouped into health insurance units (HIUs). These are units of people likely to purchase health insurance together. Average family size under this definition is slightly smaller compared to CPS-defined families.

Pricing

- We adjust non-group premiums (calibrated to match the Gruber estimates) for health using information from the 1996 MEPS and for age, sex, and census region using Actuarial Research Corporation estimates.
- Group premiums for the uninsured are imputed to follow the distribution by firm size among the insured.
- Employer shares of group premiums for those without employer-sponsored insurance are imputed in a similar fashion.
- Each HIU is assigned a nongroup and group premium for the family.

Firm behavior

- After randomly assigning CPS workers to synthetic firms, we calculate the mean wage of each firm. Each firm represents a cell with a unique combination of region, firm size, industry, and insurance offering. We then randomly assign the mean wage for each cell according to the distribution created by our synthetic firms.
- We assume benevolence on behalf of firms. If the mean employee of a firm would be better off purchasing health insurance at a subsidized rate in the nongroup market, then the employer reduces its share of the group premium accordingly.

When the mean employee faces a zero subsidized price in the nongroup market, the employer drops coverage altogether.

Assignment of tax credits
- The basic tax credit is assigned to single individuals and families in a manner consistent with the structure and phase-out described by Zelenak. We assume that tax credits are NOT age-/sex-adjusted. Comparisons should be made to the non age-/sex-adjusted column for Zelenak in the side-by-side.

Crowd-out
- We ignore all anti-crowd-out provisions on the basis that they would be difficult to effectively enforce.

Curtis, Neuschler, and Forland

The Curtis, Neuschler, and Forland 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. We do not have data that supports this grouping by employer size, so we estimated the proposal twice, using 25 and 100 as firm size cutoffs.

Everything else about the two simulations of this plan is identical. In particular, key aspects of the simulations are as follows:

Pricing
- Pool premiums are the base nongroup premium less 5 percent. They are adjusted for age, sex, and census region only. They are not adjusted for health status.

Firm behavior
- To determine whether a person is an employee of a low-wage firm eligible to offer employer-sponsored insurance through purchasing pools, we use the wage of the mean employee of that person's firm.
- Because premiums are no longer health rated, there are fewer firms in which the mean employee would face a zero price in the non-group market. Thus, firm dropping falls in our model.

Take-up
- Since pools may develop plans that will interact with Medicaid and CHIP coverage, anyone with a family member eligible for Medicaid or CHIP is assumed

to be 1.5 times more likely to purchase insurance through a pool, with or without a tax credit. People with a family member enrolled in Medicaid or CHIP are 2 times more likely to participate. These are arbitrary factors that are used consistently for all proposals in which this aspect is relevant.

- The greater incentive for participation among the less healthy is incorporated into the model through the absence of health adjustments in pool premiums.
- Anyone currently covered by employer-sponsored insurance whose firm newly offers insurance through a purchasing pool automatically switches to (employer-sponsored) pool coverage.

Fuchs

The Fuchs proposal would permit anyone qualifying for a tax credit and employees of small firms (<10 workers) to purchase health insurance through an Extended Federal Employees Health Benefit Program (E-FEHBP). Simulation details specific to this plan can be summarized as follows:

Eligibility

- While we ignore the small firm eligibility requirement of minimum employee participation rates and the stipulation that firms not have offered ESI in the last six months, we do impose a 75 percent employer contribution requirement.

Pricing

- Projections of E-FEHBP premiums depend on assumptions about the levels of reinsurance. We estimated take-up for this proposal twice using information provided by Actuarial Research Corporation. First, assuming the top 0.25 percent of the population would use the reinsurance pool, we ran our model using a starting E-FEHBP premium that was 9 percent less than the base nongroup price. We then estimated again, assuming 1 percent cedes to the reinsurance pool and E-FEHBP premiums equal to the base nongroup price less 19 percent.
- E-FEHBP premiums were adjusted for census region only.

Firm behavior

- Because premiums are no longer age, sex, or health rated, there are fewer firms in which the mean employee would face a zero price in the non-group market. Thus, firm dropping falls in our model.

Take-up

- Since E-FEHBP may develop plans that will interact with Medicaid and CHIP coverage, anyone with a family member eligible for Medicaid or CHIP is assumed to be 1.5 times more likely to purchase insurance through a E-FEHBP, with or without a tax credit. People with a family member enrolled in Medicaid or CHIP are 2 times more likely to participate. These are arbitrary factors that are used consistently for all proposals in which this aspect is relevant.
- Similarly, we assume residents of Washington, D.C. to be 2 times more likely to participate given the wide range of coverage plans available in the Washington, D.C. area due to its high density of federal workers.
- The greater incentive for participation among the less healthy is incorporated into the model through the absence of health adjustments in E-FEHBP premiums.
- Anyone currently covered by employer-sponsored insurance whose firm newly offers insurance through E-FEHBP automatically switches to (employer-sponsored) E-FEHBP coverage.

Weil

The Weil proposal would permit, but not require, tax credit recipients to buy into Medicaid or CHIP.

Pricing

- Quality-adjusted Medicaid/CHIP premiums are the base nongroup premium less 5 percent. They are adjusted for age, sex, and census region only. They are not health-adjusted.

Firm behavior

- Because premiums are no longer health rated, there are fewer firms in which the mean employee would face a zero price in the non-group market. Thus, firm dropping falls in our model.

Take-up

- Since this plan provides access to Medicaid and CHIP coverage, anyone with a family member eligible for Medicaid or CHIP is assumed to be 1.5 times more likely to purchase insurance through this plan. People with a family member enrolled in Medicaid or CHIP are 2 times more likely to participate. These are arbitrary factors that are used consistently for all proposals in which this aspect is relevant.

- The greater incentive for participation among the less healthy is incorporated into the model through the absence of health adjustments in Medicaid/CHIP premiums.

Meyer and Wicks

The employer-based federal tax credit plan proposed by Meyer and Wicks takes a different approach than the Zelenak plan. First we simulate firm take-up and then examine individual behavior.

Eligibility

- To be eligible, firms must contribute at least 50 percent of the full cost of group insurance. We have this data for only those persons currently employer-insured. Therefore, average employer shares by firm size were assigned randomly to those not currently taking ESI.
- To determine whether a person is an employee of a low-wage firm eligible to receive a tax credit, we use the wage of the mean employee of that person's firm.

Firm take-up

- We assume that all eligible firms currently offering ESI accept the tax-credit.
- We apply the standard take-up elasticity assumption to the mean worker in a firm to determine whether an eligible firm not currently offering ESI takes-up and begins offering.

Individual take-up

- Anyone currently insured through an employer takes up. We assume take-up extends to all family members as well.
- We divided those with nongroup coverage whose employer takes up into two groups. Those whose firm currently offers ESI were subjected to the standard elasticity assumption. Anyone whose firm does not currently offer insurance now accepts the new offer.
- Only uninsureds currently without an offer were permitted to switch to ESI given their employer takes up. The standard elasticity assumption holds here.

Tax credit amount

- The plan proposes a tax credit fixed at 50 percent of the nationwide average cost of a "standard benefit package." For this nationwide average cost, we took the average single and family group premiums in 1997 reported by the MEPS and

added a loading factor to account for inflation in medical care, obtained from Bureau of Labor Statistics data, to make the cost applicable to 1999.

Rosenbaum, Borzi, and Smith

The Rosenbaum, Borzi, and Smith plan offers a compromise between individual and employer tax credit plans by awarding both. The actual structure of the tax credit would be determined by participating states, and Rosenbaum, Borzi, and Smith offer two suggestions. Eligibility could be determined using family income or individual hourly wage rates. In order to accommodate both scenarios, we estimated this plan using each criterion. All other details of the methodology remain the same for both simulations.

Pricing

- Quality-adjusted E-CHIP premiums are the base nongroup premium less 5 percent. They are adjusted for age, sex, and census region only. They are not health-adjusted.

Firm take-up

- We assume that all eligible firms currently offering ESI accept the tax-credit.
- We applied the standard take-up elasticity assumption to the mean worker to determine whether eligible firms not currently offering ESI take-up and begin offering.

Individual take-up

- Anyone currently insured through an employer takes up. We assume take-up extends to all family members as well.
- We divided those with nongroup coverage whose employer takes up into two groups. Those whose firm currently offers ESI were subjected to the standard elasticity assumption. Anyone whose firm does not currently offer insurance now accepts the new offer.
- Only uninsureds currently without an offer were permitted to switch to ESI given their employer takes up. The standard elasticity assumption holds here.
- Anyone with a family member eligible for Medicaid or CHIP is assumed to be 1.5 times more likely to buy into Medicaid/CHIP, with or without a tax credit. People with a family member enrolled in Medicaid or CHIP are 2 times more likely to participate. These are arbitrary factors that are used consistently for all proposals in which this aspect is relevant.

- The greater incentive for participation among the less healthy is incorporated into the model through the absence of health adjustments in E-CHIP premiums.

Short, Shea, and Powell

The Short, Shea, and Powell proposal would provide vouchers to pre-Medicare aged workers with low-lifetime incomes.

Eligibility

- The CPS does not provide information on lifetime income. Assuming that income at ages 52 to 54 is a good proxy for lifetime income, we used data from the March 1989 CPS to impute this measure. We grouped the population ages 52 to 54 in 1989 by age, race, and education and applied the percentage of each group with incomes below 200 percent FPL to the same groups 10 years later.

Pricing

- To estimate Medicare premiums, we reduce the base non-group premium by 15 percent to reflect narrower coverage and administrative savings, and then raise it by 10 percent to reflect selection, for a net premium of the base nongroup premium less 5 percent. These are adjusted for age, sex, and census region only. This estimate is probably too low for the estimate of option A below and too high for the estimate of option B below (where participation is nearly 100 percent).

Firm behavior

- The population is too small to affect firm behavior in response to this program.

Take-up

- We consider two options. Under option A, we simply apply the standard take-up elasticities to the expected price changes.
- Under option B, we assume that since the Social Security Administration would make a determination of eligibility at the time a person turned 62, it would automatically enroll all those eligible. In that case, we assume take-up for all people varies with subsidy levels as a percentage of premiums according to the standard rule for those currently holding non-group coverage.
- Given the difficulties in doing so, our simulation model does not accommodate the IRA portion of this proposal. We estimate take-up only for the Medicare buy-in and voucher program.