HEALTH INSURANCE TAX CREDITS: WILL THEY WORK FOR WOMEN?

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EXECUTIVE SUMMARY

The growth in the number of U.S. women who lack health insurance has accelerated in recent years to a rate three times that of men. If the trend continues, the number of uninsured women will surpass that of men for the first time in 2005. This is of great concern, since women on average have greater need for health care over their lifespan than men, including preventive services and care during pregnancies and childbirth. Recent policy proposals to reduce the number of uninsured have centered on providing low-income people with tax credits to buy health coverage in the individual insurance market. Early this year, for example, the Bush Administration proposed a refundable tax credit of up to $1,000 per year for single adults, with the credit phasing out at incomes between $15,000 and $30,000.

This study finds, however, that tax credits at the level of those in recent proposals would not be enough to make health insurance affordable to working women. Not only would tax credits buy less coverage for young women than they would for young men, in many markets no individual policies are available at all. In markets where plans are available, even young, healthy women ages 25 or 35 with annual incomes that fall in the range of current tax credit proposals ($15,000 or less) could face deductibles that would comprise as much as a third of their income for plans with $1,000 and $1,500 premiums. Despite such high deductibles, however, few of these plans include maternity coverage, which is an important benefit to many young women. Older working women fare even worse: in the few cities where individual plans are available, a woman age 50 could spend more than half of her annual income on deductibles for plans with premiums at or below $1,000.

To gauge the impact that proposed tax credits would have on the ability of uninsured working women to purchase health insurance in the individual market, we relied on a website that provides information on individual health coverage, www.ehealthinsurance.com. We collected premium quotes and benefit information for healthy, nonsmoking women and men ages 25, 35, and 50 in 25 cities throughout the country from April to August of 2002. To see how women might fare with the tax credits considered in recent proposals, we examined the types of individual insurance policies that are available for women at annual premiums of $1,000 and $1,500. The report looks at women's likely premium costs for low-deductible ($250 or less) policies that are comparable to policies prevailing in the group market and to those currently covering federal employees and members of Congress. Plans included in the analysis were required to have some degree of prescription drug coverage, some coverage of doctors' office visits,

and a cap on out-of-pocket expenses. Information was obtained for women and men in excellent health who do not smoke.

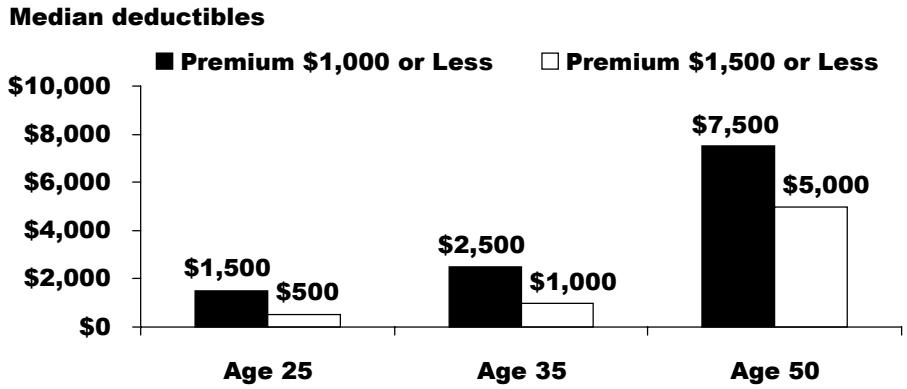
Following are some of the key findings from the study:

$1,000-Premium Health Plans

- A $1,000 premium would not buy women in excellent health access to a plan in all of the 25 cities examined. Access to coverage worsened with age: $1,000-premium plans were available in 20 cities for 25-year-old women, 17 cities for 35-year-old women, and just two cities for 50-year-old women.
- All $1,000-premium plans examined included high front-end deductible requirements that increased sharply with age. Median annual deductibles were $1,500 for 25-year-old women and $2,500 for 35-year-olds. In the two markets in which women at age 50 could find an individual plan, deductibles were $5,000 and $10,000 (Figure ES-1).

Figure ES-1. Median Deductibles for Plans with Premiums of $1,000 or Less and $1,500 or Less

Healthy Women Ages 25, 35, and 50



Note: Most plans do not include maternity benefits.
Source: Analysis of data collected from ehealthinsurance.com, April–August, 2002.

- Men had access to more $1,000-premium plans and faced lower deductibles than women did, but their choices declined and deductibles rose with age. The median deductibles for men were $1,000 for 25-year-olds and $2,250 for 35-year-olds.

Only one city had a plan available to 50-year-old men, and that plan had a $10,000 deductible.

- The deductibles of $1,000-premium plans translate into substantial economic burdens for women and men with annual incomes that fall in the range of current tax credit proposals. As a percentage of a $15,000 annual income, deductibles ranged from medians of 10 percent and 7 percent, respectively, for 25-year-old women and 25-year-old men; to 17 percent and 15 percent, respectively, for 35-year-old women and men; to 50 percent or more for 50-year-old women and men.

$1,500-Premium Plans

- Raising the amount of the premium to $1,500 increased access to plans for women at all ages. A larger number of cities also had plans with lower deductibles, so that median deductibles fell to $500 for 25-year-old women and $1,000 for 35-year-old women. Yet, older women remained severely handicapped by their age; the median deductible for 50-year-old women was high—$5,000 (Figure ES-1).

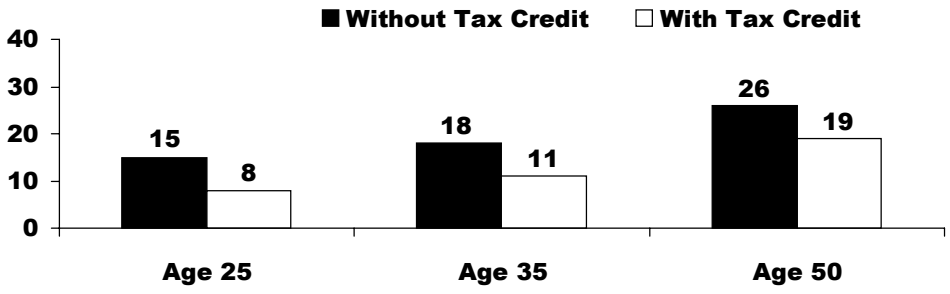
Low-Deductible Plans

- Plans with deductibles comparable to those in plans that federal employees and members of Congress are offered ($250 or less) in general had premiums more than double a $1,000 tax credit. The median premiums for low-deductible plans were $2,016 for 25-year-old women, $2,448 for 35-year-old women, and $3,548 for 50-year-old women.

- As a share of a $15,000 annual income, the median sum of these premiums and deductibles for women ranged from 15 percent for 25-year-olds, to 18 percent for 35-year-olds, to 26 percent for 50-year-olds. A $1,000 tax credit would reduce those shares to 8 percent, 11 percent, and 19 percent for 25-year-olds, 35-year-olds, and 50-year-olds, respectively (Figure ES-2).

Figure ES-2. Premiums for Plans with Deductibles of $250 or Less as a Share of Annual Income with and Without a $1,000 Tax Credit

Median for Healthy Women Ages 25, 35, and 50



Note: Most plans do not include maternity benefits.
Source: Analysis of data collected from ehealthinsurance.com, April–August, 2002.

Maternity Benefits

- Maternity benefits were rarely included in health plans' base premium rates. In the majority of cities, health plans that were available for women either did not include maternity benefits at all, sold them as a separate rider at additional cost, severely limited benefits, or imposed long waiting periods. Increasing the premium to $1,500 did not increase availability of maternity coverage. Even low-deductible plans with high premiums did not, in most cases, include maternity benefits.

Regional Cost Differences

- Flat-rate tax credits of $1,000 or $1,500 would buy substantially different benefits for women of the same age with the same health characteristics living in different parts of the country. There were no consistent regional patterns across the cities examined.

CONCLUSION

This study found that low-income women would be hard-pressed to find an affordable health plan, even if they were in excellent health. In many cities, it would be hard for women to find a plan at all. Moreover, research has indicated that people in poor health or with only minor health conditions have even fewer options or face higher premiums and more limited benefits than people in excellent health. Given that just one of four uninsured women in the United States rates their health as excellent, the majority of

uninsured women would likely face significantly higher premiums than those examined for this report.

To make a tax credit program work better for both men and women, some have proposed that the federal government limit the extent to which rates charged within markets for insurance plans can vary by sex, age, or health characteristics. Attempts to do this in the individual market at the state level have had mixed results, however. Some have also suggested that the imposition of minimum benefit standards or a requirement that health plans offer at least one standardized benefit plan would help guarantee access to benefits such as maternity coverage. Other actions suggested by researchers to improve the functioning of the individual market include the creation and subsidization of high-risk insurance pools and the involvement of the federal government as a reinsurer for people who have health expenditures that are among the highest 2 to 3 percent. Alternatively, tax credits or premium subsidies might be coupled with options for low-income uninsured people to buy insurance in the group market, which pools health risks across gender, age, and other variables.

Even if coupled with group options, however, any tax credit or premium assistance based on flat rates would still confront geographic variations in premiums and underlying health care costs. The variations observed in this 25-city study of the individual insurance market most likely reflect underlying differences in provider fees and patterns of care across markets, the particular dynamics of the individual insurance market, and state variations in regulations affecting policies sold on an individual basis. The lack of distinct regional patterns in health plan costs means that there is no simple way to provide flat-rate premium assistance that would buy a similar package of benefits for working people with low incomes across the country.

HEALTH INSURANCE TAX CREDITS: WILL THEY WORK FOR WOMEN?

INTRODUCTION

Nearly 41.2 million Americans—nearly 15 percent of the U.S. population—went without health insurance in 2001, an increase of 1.4 million people from 2000.[1] To reduce the number of uninsured, Congress and the Bush Administration recently outlined proposals that would provide tax credits to help low-income adults and families purchase insurance in the private, individual insurance market. Early this year, the Bush Administration proposed a refundable tax credit of up to $1,000 a year for single adults, with the credit phasing out at incomes between $15,000 and $30,000.[2] Although such a policy is well targeted—more than half of those without insurance earn less than $20,000 per year—there is concern that the $1,000 credit would not be sufficient to enable adults with incomes below $15,000 to purchase affordable coverage of reasonable quality.[3,4]

Women currently comprise just under one-half of the uninsured, but the welfare changes of the 1990s and lower health insurance offer rates to women by employers have contributed to a rate of growth in the uninsured rate for women that has outpaced that for men in recent years.[5] By 2005, more women than men are expected to be uninsured.[6] This is of great concern, since women on average have greater need for health care over their lifespan than men, including preventive services and care during pregnancies and childbirth.[7] Women also are more prone to chronic illness and are more likely to use mental health care and prescription drugs.

Such greater health care need translates into higher expected medical costs over a woman's lifetime, which insurers are likely to take into account when they set insurance premiums for policies sold on the individual market.[8] At younger ages in particular, adult women are likely to face higher premium costs in the individual market than their male counterparts. Even at lower fixed premium rates, women are likely to be offered plans with fewer benefits than those offered to men of similar age and health.

Gender-related premium differentials thus pose a challenge for proposals that would couple tax credits with purchase of policies sold in the individual insurance market. To see how women might fare with the tax credits considered in recent proposals, this study examines the types of individual insurance policies that are available for healthy, nonsmoking women in 25 cities across the country at annual premiums of $1,000 and $1,500. The report also examines the likely premium costs for women if they tried to

purchase a policy with low deductibles, comparable to policies prevailing in the group market and currently covering federal employees and members of Congress. For the purposes of comparison, we also examine the types of policies that would be available to healthy, nonsmoking men on the individual market for a $1,000 premium.

The analysis explores how financial protections and the scope of benefits, including maternity benefits, vary by a woman's age and area of residence. The cities included in the study represent major markets in 25 different states, which together account for nearly 75 percent of the U.S. population. The cities were selected for geographic diversity and because they are representative of different regulatory approaches to individual insurance markets.

METHODOLOGY

Using an online site that provides information on individual health coverage, www.ehealthinsurance.com, we collected premium quotes and benefit information for healthy, nonsmoking women and men ages 25, 35, and 50 in 25 cities from April to August of 2002. To ensure that the cities represented a high proportion of the U.S. population, we selected the 10 most populous U.S. states (with populations of 8 million or more) and then selected the largest city within each. To ensure a range of market sizes, we selected the capital city in three of the smallest states (with populations of less than 1 million). We also selected cities from different regions of the country with varying degrees of individual market regulation.[9] Under these criteria, the final sample includes six states from the West, seven states from the Midwest, six states from the South, and six from the Northeast and Mid-Atlantic regions of the country.[10] Of these, two states—New York and New Jersey—require health plans to charge the same rate for the same benefit package irrespective of age, sex, or health status.

To ensure that all plans covered a range of basic medical care services as well as some protection against large medical bills, we restricted the analysis to plans that included at least some coverage of physician office visits, some coverage of prescription drugs (even if only a discount card), and some limit on a patient's out-of-pocket expenses. Using these basic criteria, we examined the types of individual insurance policies that would be available to healthy women at ages 25, 35, and 50 for annual premiums of $1,000 and $1,500. These premium levels were selected to be at or within 50 percent of the levels under consideration in recent tax credit proposals. If more than one plan met the selection criteria, we selected the "best" plan for the given premium rate by first choosing the plan with the lowest deductibles and then choosing the plan with the lowest cost-sharing.

To see how premiums might change if women were to seek plans with deductibles comparable to those typical in the employer-sponsored group insurance market, we obtained premium quotes for women in each city for an annual deductible of $250 or less. This level is similar to the deductibles in the most popular plan among federal employees and to the $270 average employer-sponsored group insurance deductible reported in a 2002 employer benefit survey.[11]

This study design resulted in three different types of plans for each of the three age groups of women within each of the 25 city markets. For comparison purposes, we also examined what a $1,000 annual premium would buy healthy men at each of the three age levels in each market.

With the exception of New York and New Jersey, all the rates in the report reflect quotes for a healthy woman or man who does not smoke. In most states, premiums would be higher if the applicant had a past history of health problems, was in poor health or had chronic health conditions, was a smoker, or otherwise fell into some higher-risk category known to insurers.[12] A series of tables summarizes results of the study for the three types of plans and the appendix provides detailed findings for plans by city.

FINDINGS

What Plans Are Available to Women for a $1,000 Premium? How Do They Compare with Those Available to Men?

The study found that a $1,000 premium would not buy all women access to a health plan in all of the 25 cities, and that access worsened with age. Women at age 50 had the worst prospects: only those living in Cleveland and Baltimore could find a carrier willing to sell coverage in their age group for a $1,000 annual premium. At age 25, a healthy woman could find a plan with a $1,000 premium in 20 of 25 cities. Options fell for 35-year-old healthy women, who could purchase plans for $1,000 premiums in only 17 of the 25 cities (Table 1).

Table 1. Availability of Individual Health Insurance Plans for Premiums of $1,000 or Less, Women and Men Ages 25, 35, and 50

	WOMEN			MEN		
THE NUMBER…	**Age 25**	**Age 35**	**Age 50**	**Age 25**	**Age 35**	**Age 50**
Of cities studied	25	25	25	25	25	25
With at least one plan	20	17	2	22	20	1
Where plan deductible★ is…						
$500 or less	1	1	0	5	1	0
$501–$1,000	8	0	0	12	2	0
$1,001–$2,499	5	1	0	3	7	0
$2,500–$4,999	3	8	0	0	9	0
$5,000 or more	3	7	2	2	1	1
Median deductible	$1,500	$2,500	$7,500	$1,000	$2,250	$10,000

★ In-network deductibles are presented. Out-of-network deductibles are higher.

Source: Authors' compilation based on quotes from www.ehealthinsurance.com, April–August, 2002.

In the cities where plans were available, all plans included high front-end deductible requirements that increased sharply with age. In the 20 cities in which 25-year-old women could find a plan, median annual deductibles were $1,500, ranging from $500 in Los Angeles to $5,000 in three cities: Atlanta, Kansas City, and Miami (Tables 1 and 2). For 35-year-old women, the median deductible in 17 cities was $2,500 and ranged from $500 in Los Angeles to $5,000 in seven cities. In the only two markets in which women at age 50 could find a plan, deductibles were $5,000 (Cleveland) and $10,000 (Baltimore). Thus, the median deductible for 50-year-old women is more than five times the median deductible for the plans available to 25-year-old women.

Younger men (ages 25 or 35) would have access to $1,000-premium plans in more cities and would generally face lower deductibles than would women of the same age (Tables 1 and 2). At age 25, men would have access to plans in 22 of the 25 cities, while 35-year-old men would have access to only 20 plans. The median deductible for 25-year-old men was $1,000 and ranged from $500 in five cities to $5,000 in two cities. At age 35, median deductibles for men climbed to $2,250, with a range of $500 to $5,000. Like 50-year-old women, 50-year-old men would have little access to affordable health coverage. Only one city (Baltimore) had a $1,000-premium plan available to 50-year-old men, and this plan included a $10,000 deductible.

Table 2. Deductibles* of Best Plan for Premiums of $1,000 or Less in Each Market, Women and Men Ages 25, 35, and 50**

	WOMEN			MEN		
CITY, STATE	**Age 25**	**Age 35**	**Age 50**	**Age 25**	**Age 35**	**Age 50**
Cleveland, OH	$1,000	$2,500	$5,000	$500	$1,500	No Plan
Baltimore, MD	$800	$2,500	$10,000	$750	$1,500	$10,000
Los Angeles, CA	$500	$500	No Plan	$500	$500	No Plan
Houston, TX	$2,000	$2,000	No Plan	$1,500	$2,000	No Plan
Cheyenne, WY	$1,000	$2,500	No Plan	$500	$1,000	No Plan
Denver, CO	$1,000	$2,500	No Plan	$1,000	$1,500	No Plan
Des Moines, IA	$1,000	$2,500	No Plan	$750	$1,500	No Plan
Hartford, CT	$1,000	$2,500	No Plan	$750	$1,500	No Plan
Philadelphia, PA	$1,000	$2,500	No Plan	$1,000	$1,500	No Plan
Seattle, WA	$1,000	$2,500	No Plan	$1,000	$2,500	No Plan
Chicago, IL	$1,500	$5,000	No Plan	$1,500	$3,000	No Plan
Durham, NC	$1,500	$5,000	No Plan	$500	$1,000	No Plan
Detroit, MI	$1,650	$5,000	No Plan	$1,000	$2,500	No Plan
Phoenix, AZ	$1,650	$5,000	No Plan	$750	$2,500	No Plan
Milwaukee, WI	$2,500	$5,000	No Plan	$1,000	$2,500	No Plan
Nashville, TN	$2,500	$5,000	No Plan	$1,000	$2,500	No Plan
Pierre, SD	$2,500	$5,000	No Plan	$500	$2,500	No Plan
Atlanta, GA	$5,000	No Plan	No Plan	$1,000	$2,500	No Plan
Kansas City, KS	$5,000	No Plan	No Plan	$1,000	$2,500	No Plan
Miami, FL	$5,000	No Plan	No Plan	$1,500	$5,000	No Plan
Helena, MT	No Plan	No Plan	No Plan	$5,000	No Plan	No Plan
New Orleans, LA	No Plan	No Plan	No Plan	$5,000	No Plan	No Plan
Newark, NJ	No Plan	No Plan	No Plan	No Plan	No Plan	No Plan
New York, NY	No Plan	No Plan	No Plan	No Plan	No Plan	No Plan
Providence, RI	No Plan	No Plan	No Plan	No Plan	No Plan	No Plan

* In-network deductibles are presented. Out-of-network deductibles are higher.

** Best plans in a market are those that include coverage of prescription drugs and doctors' office visits, a cap on out-of-pocket expenses, the lowest deductibles, and the lowest cost-sharing.

Source: Authors' compilation based on quotes from www.ehealthinsurance.com, April–August, 2002.

Even if a tax credit covered the entire cost of the annual premium, the deductibles of these $1,000-premium plans translate into substantial economic burdens for women and men with annual incomes of $15,000. Table 3 shows deductibles for these plans as a percentage of income.[13] Women at age 25 could potentially spend 10 percent or more of their income on deductibles in more than half the cities in which they could find coverage. Young men, by comparison, might spend that amount in just five of 23 cities.

Table 3. Deductibles* as a Percent of Annual Income of $15,000 for Plans with Premiums of $1,000 or Less, Women and Men Ages 25, 35, and 50

	WOMEN			MEN		
	Age 25	**Age 35**	**Age 50**	**Age 25**	**Age 35**	**Age 50**
MEDIAN	10%	17%	50%	7%	15%	67%
CITY, STATE						
Cleveland, OH	7%	17%	33%	3%	10%	No Plan
Baltimore, MD	5%	17%	67%	5%	10%	67%
Los Angeles, CA	3%	3%	No Plan	3%	3%	No Plan
Houston, TX	13%	13%	No Plan	10%	13%	No Plan
Cheyenne, WY	7%	17%	No Plan	3%	7%	No Plan
Denver, CO	7%	17%	No Plan	7%	10%	No Plan
Des Moines, IA	7%	17%	No Plan	5%	10%	No Plan
Hartford, CT	7%	17%	No Plan	5%	10%	No Plan
Philadelphia, PA	7%	17%	No Plan	7%	10%	No Plan
Seattle, WA	7%	17%	No Plan	7%	17%	No Plan
Chicago, IL	10%	33%	No Plan	10%	20%	No Plan
Durham, NC	10%	33%	No Plan	3%	7%	No Plan
Detroit, MI	11%	33%	No Plan	7%	17%	No Plan
Phoenix, AZ	11%	33%	No Plan	5%	17%	No Plan
Milwaukee, WI	17%	33%	No Plan	7%	17%	No Plan
Nashville, TN	17%	33%	No Plan	7%	17%	No Plan
Pierre, SD	17%	33%	No Plan	3%	17%	No Plan
Atlanta, GA	33%	No Plan	No Plan	7%	17%	No Plan
Kansas City, KS	33%	No Plan	No Plan	7%	17%	No Plan
Miami, FL	33%	No Plan	No Plan	10%	33%	No Plan
Helena, MT	No Plan	No Plan	No Plan	33%	No Plan	No Plan
New Orleans, LA	No Plan	No Plan	No Plan	33%	No Plan	No Plan
Newark, NJ	No Plan	No Plan	No Plan	No Plan	No Plan	No Plan
New York, NY	No Plan	No Plan	No Plan	No Plan	No Plan	No Plan
Providence, RI	No Plan	No Plan	No Plan	No Plan	No Plan	No Plan

* In-network deductibles are presented. Out-of-network deductibles are higher.

Source: Authors' compilation based on quotes from www.ehealthinsurance.com, April–August, 2002.

Women at age 35 could spend more than 15 percent of their income on deductibles in 15 of the 17 cities that had plans, compared with 10 of 20 cities for men at that age. In seven cities, 35-year-old women could spend as much as a third of their income on deductibles. While the share of income that men and women could potentially

spend on deductibles was equivalent in some cities at these ages, there were no cities in which the potential expenditure was higher for men than for women.

At age 50, both men and women faced deductibles that could consume more than 50 percent of their annual income. In the only city offering a $1,000-premium plan for both older men and women earning $15,000 a year, plan enrollees might spend as much as 67 percent of their income to meet their deductible requirements.

Maternity Benefits

Despite such high deductibles, women in most of the study cities would not have maternity benefits in these $1,000-premium plans, leaving them at additional risk for substantial out-of-pocket costs from a pregnancy. Based on this analysis, carriers on the individual market appear to protect themselves from the possible costs of pregnancies by not offering maternity benefits at all, selling the benefits as a separate rider at additional cost, limiting the scope of benefits, or imposing waiting periods of up to 24 months. Among the 20 markets in which 25-year-old women could purchase a plan with a $1,000 premium, three had plans that included maternity benefits and four had plans that would offer maternity coverage at additional cost (Table A-1). Thirty-five-year old women had even fewer options: none of the $1,000 plans that met the initial selection criteria included maternity benefits, while five cities had plans that offered maternity benefits at additional cost.

Of the health plans that included maternity benefits for 25-year-old women, the best plan in Seattle paid 80 percent of costs after the plan deductible, and the best plan in Baltimore paid 75 percent of costs after the plan deductible. The best available plan in Kansas City required a 24-month waiting period. Where plans offered maternity benefits for an additional premium, premium costs were typically high relative to the maximum amount covered by the plan. In Denver, for example, the best plan offered 25-year-old women up to a $2,500 benefit for an additional $800 premium. Even at such a high cost, the full benefit would only be paid out after the first year of a woman's enrollment; the plan paid only 50 percent of the maximum benefit during the first year.[14] In other words, during the first year, a woman would have to pay $800 for a $1,250 maternity benefit or wait until the second year and pay an additional $800 premium for a $2,500 maternity benefit.

How Much Do Benefits for Women Improve with a $1,500 Premium?

The study also examined the quality of $1,500-premium plans in the individual market, options for low-income women if the amount of the tax credit were increased or if they

were able to afford $500 in premiums over the amount of the $1,000 tax credit. The study considered how deductibles in the individual market would change at the higher-premium level and the extent to which maternity benefits would be included.

The higher premium improved access to health coverage for all women, particularly for 50-year-old women. The number of cities with plans rose from 20 to 22 for 25-year-olds, 17 to 21 for 35-year-olds, and from two to 16 for 50-year-old women (Table 4).

Deductibles also fell with the higher premium. A healthy 25-year-old woman could buy a plan with a deductible of $500 or less in 14 cities for a premium of $1,500, compared with only one city for $1,000-premium plans. Thirty-five-year-old women could purchase plans with deductibles under $1,000 in 14 markets, while only one market had deductibles under $1,000 for $1,000-premium plans.

Even with the higher premium plan, however, age remained a significant impediment to finding affordable health insurance in the individual market. Fifty-year-old women had access to insurance in more cities (16 cities had $1,500-premium plans for older women versus two under $1,000-premium plans), and yet they continued to face hefty deductibles. A plan in Los Angeles offered the lowest deductible—$1,000—and plans in Baltimore, Cleveland, and Cheyenne had $2,500 deductibles. But in 12 of the 16 cities where plans with $1,500 premiums were available to 50-year-old women, deductibles were $5,000.

Table 4. Availability of Individual Health Insurance Plans for Premiums of $1,500 or Less, Compared with Availability of Plans for Premiums of $1,000 or Less, Women Ages 25, 35, and 50

	AGE		
	25	**35**	**50**
Plans with Premiums of $1,500 or Less			
Number of cities studied	25	25	25
Number of cities with at least one plan	22	21	16
Number of cities where the plan deductible★ is:			
$500 or less	14	3	0
$501–$1,000	3	11	1
$1,001–$2,499	1	4	0
$2,500–$4,999	3	0	3
$5,000 or more	1	3	12
Median deductible	$500	$1,000	$5,000
Plans with Premiums of $1,000 or Less			
Number of cities studied	25	25	25
Number of cities with at least one plan	20	17	2
Number of cities where the plan deductible★ is:			
$500 or less	1	1	0
$501–$1,000	8	0	0
$1,001–$2,499	5	1	0
$2,500–$4,999	3	8	0
$5,000 or more	3	7	2
Median deductible	$1,500	$2,500	$7,500

★ In-network deductibles are used in analysis. Out-of-network deductibles are higher.

Source: Authors' compilation based on quotes from www.ehealthinsurance.com, April–August, 2002.

Maternity Benefits

Paying a premium of $1,500 per year rather than $1,000 did little to increase women's access to maternity benefits. Among 25-year-old women, only three cities had plans that included maternity coverage for a $1,500 premium, and one of these cities required a 24-month waiting period. Thirty-five-year-old women had access to plans in two cities that included maternity benefits, one with a 24-month waiting period. Two cities had plans that offered maternity at an additional premium for 25 year-old women, and three cities had plans with this option for 35 year-olds (Table A-3).

How Much Would Women Have to Pay for a Low-Deductible Plan Similar to Employer-Sponsored Health Insurance?

Insurance plans offered in the group market, such as those available to many people with employer-sponsored health insurance, generally have much lower deductibles than the types of plans sold on the individual market discussed in this report. For example, a 2002 survey of employers by the Henry J. Kaiser Family Foundation and Health Research and Educational Trust found that the annual deductible for single coverage averaged $270 for employer-sponsored plans.[15] The Blue Cross Blue Shield preferred provider organization offered under the Federal Employees Health Benefits Program (FEHBP), the health insurance program for federal employees and members of Congress, had a $250 deductible in 2001. The Blue Cross Blue Shield preferred provider organization was the most popular plan among federal employees covered under the FEHBP in 2001.[16]

Such lower-deductible plans are likely to be particularly attractive to low-income women since they would facilitate access to medical care without the risk of high costs. To see what women would have to pay in the individual market if they sought plans with lower deductibles, we obtained premium quotes for plans with deductibles of $250 or less that also included at least some coverage of physician visits and prescription drugs.

Much like squeezing one end of a water balloon, lowering the annual deductible for women in the individual insurance market forced substantial premium increases in most of the study cities (Table 5). The median premium for a 25-year-old woman for the lower-deductible plan was $2,016, ranging from $1,320 in Cheyenne, Wyoming, to $4,644 in Newark, New Jersey. Among 35-year-old women, the median premium was $2,448 and ranged from $1,596 in Cheyenne to $4,644 in Newark. Fifty-year-old women would face a median premium of $3,548, with a range of $2,520 in Seattle to $5,904 in New Orleans. On average, the premiums of these lower-deductible plans, even for younger women, were twice as much as a $1,000 tax credit.

Table 5. Premiums for Plans with Deductibles* of $250 or Less, Women Ages 25, 35, and 50

	WOMEN		
	Age 25	**Age 35**	**Age 50**
Median	$2,016	$2,448	$3,548
Low	$1,320	$1,596	$2,520
High	$4,644	$4,644	$5,904
Number of cities with premiums of $3,000 or more	4	8	22
CITY, STATE			
Seattle, WA	$1,584	$1,860	$2,520
Cheyenne, WY	$1,320	$1,596	$2,616
Miami, FL	$2,112	$2,172	$2,640
Pierre, SD	$1,644	$1,992	$3,012
Durham, NC	$1,524	$1,848	$3,024
Phoenix, AZ	$2,820	$2,256	$3,036
New York, NY	$3,072	$3,072	$3,072
Des Moines, IA	$1,800	$2,064	$3,096
Nashville, TN	$1,800	$2,376	$3,300
Los Angeles, CA	$1,686	$1,885	$3,312
Cleveland, OH	$1,728	$2,604	$3,420
Milwaukee, WI	$1,728	$2,100	$3,432
Kansas City, KS	$2,009	$2,629	$3,548
Baltimore, MD	$1,918	$2,361	$3,736
Philadelphia, PA	$1,956	$2,376	$3,900
Hartford, CT	$2,016	$2,448	$4,008
Detroit, MI	$2,256	$2,472	$4,044
Providence, RI	$2,616	$2,988	$4,140
Chicago, IL	$2,196	$3,144	$4,548
Newark, NJ	$4,644	$4,644	$4,644
Houston, TX	$2,820	$3,228	$4,848
Atlanta, GA	$3,358	$3,885	$5,324
Denver, CO	$2,748	$3,336	$5,460
Helena, MT	$2,748	$3,372	$5,484
New Orleans, LA	$3,300	$4,008	$5,904

* In-network deductibles are presented. Out-of-network deductibles are higher.

Source: Authors' compilation based on quotes from www.ehealthinsurance.com, April–August, 2002.

Maternity Benefits

Women might expect that maternity benefits would be included in low-deductible plans, given the associated increase in premiums. Such coverage would typically be included in basic benefit packages for women and families with employer-sponsored coverage. But in most of the 25 study cities, plans did not include maternity benefits. Even plans with the highest premium costs in many cases did not include maternity coverage. In 18 of the 25 cities, maternity benefits were not included in the best available plans for 25- and 35-year-olds (Table A-4). In the seven markets in which maternity benefits were included, coverage ranged from 100 percent in New York State to a $100 per day copay with a $1,000 maximum benefit in New Jersey.

What Difference Would a Tax Credit Make in the Decision to Buy Insurance?

Decisions about whether or not to buy health insurance are complicated and are likely to depend on the interrelationships of income, cost of health plans, and the comprehensiveness of plan benefits as well as age, health status, and other variables having to do with an individual's life situation.[17] In lieu of a more complex model that would take into account such variables, some researchers have focused on the affordability of health insurance costs, measured as a percentage of income.[18] This approach has been used most often in estimating take-up rates in public insurance programs.[19]

To examine how the affordability of low-deductible plans would change with the help of a $1,000 tax credit, we calculated what share of an eligible woman's $15,000 income would be required to meet the premium and deductible requirements, with and without the tax credit. Table 6 shows the premium and deductible costs of the best $250 deductible plans in each of the 25 cities as a share of income for women in all three age groups. Median shares were 15 percent for 25-year-olds, 18 percent for 35-year-olds, and 26 percent for 50-year-olds. Table 7 shows premium and deductible costs of the same plans, after a $1,000 tax credit, as a share of income. Median shares fell to 8 percent for 25-year-olds (ranging from 4 to 24 percent), 11 percent for 35-year-olds (6 to 24 percent), and 19 percent for 50-year-olds (11 to 34 percent).

Table 6. Premium Cost and Deductibles* as a Percent of Annual Income of $15,000, for Plans with Deductibles of $250 or Less, Women Ages 25, 35, and 50

CITY, STATE	Age 25	Age 35	Age 50
MEDIAN	15%	18%	26%
Miami, FL	14%	14%	18%
Cheyenne, WY	10%	12%	19%
Phoenix, AZ	19%	15%	20%
Seattle, WA	14%	16%	20%
Los Angeles, CA	11%	13%	22%
Durham, NC	12%	14%	22%
Pierre, SD	13%	15%	22%
Des Moines, IA	14%	15%	22%
New York, NY	22%	22%	22%
Cleveland, OH	13%	19%	24%
Nashville, TN	14%	18%	24%
Milwaukee, WI	13%	16%	25%
Baltimore, MD	13%	16%	26%
Kansas City, KS	17%	21%	27%
Philadelphia, PA	15%	18%	28%
Hartford, CT	15%	18%	28%
Detroit, MI	17%	18%	29%
Providence, RI	19%	22%	29%
Newark, NJ	31%	31%	31%
Chicago, IL	15%	23%	32%
Houston, TX	20%	23%	34%
Atlanta, GA	24%	28%	37%
Denver, CO	20%	24%	38%
Helena, MT	20%	24%	38%
New Orleans, LA	24%	28%	41%

* In-network deductibles are used in analysis. Out-of-network deductibles are higher.

Source: Authors' compilation based on quotes from www.ehealthinsurance.com, April–August, 2002.

Table 7. Premium Cost (After the $1,000 Tax Credit) and Deductibles* as a Percent of Annual Income of $15,000, for Plans with Deductibles of $250 or Less, Women Ages 25, 35, and 50

CITY, STATE	Age 25	Age 35	Age 50
MEDIAN	8%	11%	19%
Miami, FL	7%	8%	11%
Cheyenne, WY	4%	6%	12%
Seattle, WA	7%	9%	13%
Phoenix, AZ	12%	8%	14%
Los Angeles, CA	5%	6%	15%
Durham, NC	5%	7%	15%
Pierre, SD	6%	8%	15%
New York, NY	15%	15%	15%
Des Moines, IA	7%	9%	16%
Nashville, TN	7%	11%	17%
Milwaukee, WI	7%	9%	18%
Cleveland, OH	7%	12%	18%
Baltimore, MD	7%	10%	19%
Kansas City, KS	10%	14%	20%
Philadelphia, PA	8%	11%	21%
Hartford, CT	8%	11%	22%
Detroit, MI	10%	11%	22%
Providence, RI	12%	15%	23%
Newark, NJ	24%	24%	24%
Chicago, IL	8%	16%	25%
Houston, TX	14%	17%	27%
Atlanta, GA	17%	21%	30%
Denver, CO	13%	17%	31%
Helena, MT	13%	17%	32%
New Orleans, LA	17%	22%	34%

* In-network deductibles are used in analysis. Out-of-network deductibles are higher. Premium costs as a percentage of income (without deductible) would be as much as 1.7 percentage points lower.

Source: Authors' compilation based on quotes from www.ehealthinsurance.com, April–August, 2002.

What impact would these increases in affordability have on the likelihood that healthy low-income women in these three different age groups would purchase health plans? Leighton Ku and Teresa Coughlin (1999) examined take-up rates in four states that implemented public insurance expansions to low-income adults using sliding-scale premiums.[20] They found that take-up as a percentage of the eligible uninsured was

inversely related to premiums as a percentage of income. Pooled data from three states showed that increasing premium shares from 1 percent to 3 percent of family income decreased participation rates from 57 percent to 35 percent. Raising contributions to 5 percent of income further decreased participation rates to 18 percent. Participation rates fell to negligible levels when premium shares were 8 percent or higher—the levels faced by most low-income women in this analysis, even after the tax credit.

This study finds that premiums net of the tax credit for plans with $250 deductibles would be in the range of 5 percent or less of a $15,000 income in just 11 out of 25 cities for 25-year-old women, three of 25 cities for 35-year-olds, and none of the cities in the case of 50-year-olds (Table 7). (Table 7 includes both the premiums and deductibles as a share of income. Without the $250 deductible, shares are as much as 1.7 percentage points lower than those that appear in the table, meaning that 11 plans would fall in the range of 5 percent.) Thus, based on these three state experiences, with the exception of younger women in certain cities, participation in individual health insurance plans would most likely be very low even with the $1,000 tax credit.[21] A similar scenario might be expected in the case of the $1,000-premium plans, in which steep deductible requirements translate into substantial shares of a $15,000 income (Table 3).

Health Status and Income: Premiums Likely to Be Higher for Most Uninsured Women

For this analysis, premiums were collected for lowest-cost scenarios—for people in excellent health who do not smoke. The risk of health problems increases with age, but even young women and men have health conditions such as hay fever or asthma that can increase the price of an individual insurance policy, result in limited benefits, or bring on a denial of coverage.[22] This means that as a share of income, premiums faced by people in less than excellent health would exceed the levels calculated in Tables 6 and 7. For example, a recent study of people with individual insurance policies found that an average premium for a person in poor health was greater than the average premium for someone of the same age in excellent health by a factor of 50 percent or more.[23]

Based on the self-reported health status of uninsured women in the annual U.S. Census Bureau's Current Population Survey, only 23 percent of women rate their health as excellent and another 32 percent rate their health as very good. Thus, only 55 percent of uninsured women would be likely to qualify for the premiums discussed in this report (Table 8). At least 45 percent and as many as 77 percent of uninsured women would face significantly higher premium costs. As illustrated in Table 8, health status declines with age: 29 percent of uninsured women ages 19 to 29 report that they are in excellent health compared with 24 percent of women age 30 to 39, 20 percent of women ages 40 to 49,

and 16 percent of women age 50 to 64. Shares of women who reported excellent health tended to be lowest among those women whose incomes would be low enough to make them eligible for the tax credit.[24]

Table 8. Health Status of Uninsured Women by Age and Income, 2000

		Annual Income			
Age Group/Health Status	**Total**	**Less than $15,000**	**$15,000–$24,999**	**$25,000–$34,999**	**$35,000 or more**
All Ages		**Percentage of All Uninsured Women**			
Excellent Health	23%	21%	22%	24%	29%
Very Good Health	32%	28%	32%	33%	37%
Good Health	32%	35%	35%	31%	27%
Fair or Poor Health	12%	15%	12%	12%	8%
Total (thousands), All Ages	14,083	6,138	2,859	1,696	3,348
Ages 19–29		**Percentage of 19–29-Year-Olds**			
Excellent Health	29%	28%	25%	29%	38%
Very Good Health	35%	33%	37%	37%	39%
Good Health	30%	33%	33%	29%	19%
Fair or Poor Health	5%	6%	5%	6%	3%
Total (thousands), Ages 19–29	4,891	2,606	958	536	749
Ages 30–39		**Percentage of 30–39-Year-Olds**			
Excellent Health	24%	20%	23%	23%	30%
Very Good Health	34%	31%	34%	36%	38%
Good Health	32%	37%	32%	30%	26%
Fair or Poor Health	10%	11%	11%	11%	5%
Total (thousands), Ages 30–39	3,364	1,206	746	548	864
Ages 40–49		**Percentage of 40–49-Year-Olds**			
Excellent Health	20%	16%	20%	18%	26%
Very Good Health	30%	24%	28%	34%	36%
Good Health	34%	35%	38%	30%	31%
Fair or Poor Health	16%	25%	15%	17%	6%
Total (thousands), Ages 40–49	2,874	1,081	609	305	879
Ages 50–64		**Percentage of 50–64-Year-Olds**			
Excellent Health	16%	12%	16%	20%	21%
Very Good Health	25%	20%	23%	23%	34%
Good Health	35%	37%	38%	38%	30%
Fair or Poor Health	24%	31%	23%	19%	15%
Total (thousands), Ages 50–64	2,954	1,245	546	307	856

Source: Commonwealth Fund Task Force on the Future of Health Insurance analysis of March 2001 Current Population Survey.

Prescription Drug Benefits

Although one of the study's criteria for including a plan in this analysis was some form of prescription drug coverage, we found that the basic prescription drug benefit for the lower-cost premium plans was often limited. Thus, out-of-pocket costs for prescription drug benefits in many markets had the potential to be very high. Prescription drug coverage among the plans studied fell into four general categories: 1) discount cards; 2) coverage with an extra deductible or high cost-sharing for prescription drugs; 3) coverage only after the plan deductible is met, similar to other covered services; 4) drug benefits with copayments or cost-sharing, similar to benefits in the employer-sponsored group insurance market.

The majority of plans that qualified as "best" plans in markets under the selection criteria required some form of a deductible before drug coverage became active (Tables A-1–A-4). In about half the cities in which $1,000-premium plans were available for 25- and 35-year-old women, enrollees were required to meet the plan deductible prior to receiving drug coverage. The median deductible for this group of plans was $1,500 for 25-year-old women and $2,500 for 35-year-old women. Coverage ranged from 75 to 100 percent after the deductible requirement. Of the two $1,000-premium plans available to 50-year-old women, one plan in Baltimore mandated a deductible of $10,000 and then covered 80 percent of drugs up to a $500 annual limit.

Discount cards or discount programs were also prevalent either in combination with a deductible or as the sole prescription drug benefit. In nine of the 25 cities, some type of pharmaceutical discount constituted the full drug benefit for women in all three age groups under the $1,000- and $1,500-premium plans (Tables A-1 and A-3). Only five of the 25 cities had $1,000- or $1,500-premium plans that included drug coverage with a copayment or coinsurance without a deductible (Tables A-1 and A-3).

Geography Matters

A flat-rate tax credit of $1,000 or $1,500 would buy substantially different benefits for women of the same age and health characteristics who live in different parts of the country. For example, a 35-year-old woman living in Nashville would face a $5,000 deductible if she buys a plan with a $1,000 premium on the individual market (Table 2). But a woman of the same age and health profile living in Los Angeles would face a $500 deductible for a $1,000-premium plan.

As result of these geographic variations, women with low incomes across the country would fare very differently under a federal tax credit program. Under a $1,000-

premium plan, deductibles would represent 33 percent of a 35-year-old Nashville woman's annual $15,000 income, compared with just 3 percent of the same income for a woman of the same age in Los Angeles (Table 3).

The considerable variation in health insurance costs across regions did not fit into any consistent patterns. Costs were different in adjacent states (South Dakota and Wyoming) and between cities of similar size (New York, Los Angeles, and Chicago) and region (Detroit and Cleveland). This finding indicates that policymakers would have a difficult time designing a tax credit program that would treat people with low incomes equally across the country.

CONCLUSIONS AND POLICY IMPLICATIONS

This study's findings indicate that for healthy working women, tax credits to purchase health insurance on the individual market would buy less generous coverage at younger ages than they would for younger men. In many markets, there may be no individual policies available to women at all, even for a $1,500 premium. In markets where plans are available, even young, healthy women ages 25 or 35 with annual incomes low enough to qualify for the full tax credit ($15,000 or less) would face high deductibles relative to their income for plans with $1,000 and $1,500 premiums. In study cities, young women would be at risk for out-of-pocket costs in the form of deductibles that could consume as much as a third of their annual income if they bought plans with premiums in this range. In the few cities where plans were available for them, older women and men (age 50) could spend more than half their annual income on deductibles for plans with premiums at or below $1,000.

Young men in general had a greater range of plan options and more affordable choices than young women. At premiums of $1,000 or $1,500, young men in most cities studied would be more likely to find plans and to find plans with better benefits (e.g., lower deductibles) than would women of similar age and health status. For older adults, male and female, plans were less available and deductibles were less affordable.

Most low-income women who sought coverage in plans with premiums of $1,500 or less would most likely be at full risk for the costs of maternity care in the event of a pregnancy. Very few plans in this study included maternity benefits for the annual premium costs. In the majority of cities, health plans that were available for women either did not include maternity benefits at all, sold them as a separate rider at additional cost, severely limited benefits, or imposed long waiting periods. In light of evidence that suggests that at least half of all pregnancies are unplanned, women who purchase plans like

these remain vulnerable to substantial out-of-pocket costs that could turn catastrophic in the event of a complicated—or even a normal—pregnancy and childbirth.[25]

If low-income women tried to minimize their risk of high out-of-pocket costs for medical bills relative to their income by finding plans with low front-end deductibles, they would most likely experience a sharp increase in premiums. Even for younger women, premiums for low deductible plans ($250 or less) sold on the individual market substantially exceeded the $1,000 per year tax credit included in recent proposals. The high cost of low-deductible plans in the individual insurance market means that the tax credit would offset only a portion of the costs of health insurance, leaving a considerable economic burden on the low-income individuals who would be eligible for the credit.

The lack of plans with premiums in the range of the proposed tax credits ($1,000–$1,500) and the high front-end deductibles found in the plans available to women cast doubt on whether tax credits currently under consideration would have more than a marginal impact on the number of healthy, uninsured women. It is unlikely that women with $15,000 incomes would be able to afford a policy that could consume a third of their income in potential deductibles, but still leave them without maternity benefits. Nor is it likely that these low-income women would be able to allocate 10 to 20 percent of their annual income toward a premium of a plan with lower deductibles. Indeed, based on the experience of state public insurance expansions for low-income adults that used sliding-scale premiums, participation rates would most likely be negligible where premiums exceeded 5 percent of income.[26]

Moreover, the premiums collected in this report are for nonsmoking women and men in excellent health. There is evidence that even minor health problems can increase the likelihood that people who apply for individual health insurance policies will be denied coverage or face limits on benefits and/or substantial increases in premiums or deductibles.[27] Given that just one of four uninsured women in the United States rate their health as excellent, the majority of uninsured women would very likely face significantly higher premium costs than those discussed here.[28]

Tax credit policies also raise an additional set of concerns. First, a policy that would in effect provide more generous benefits to low-income men than low-income women would be inherently inequitable. In addition, given the geographic variation in premiums observed across the 25 cities and within regions of the country, a flat-rate tax credit would confer very different benefits on women in different regions of the country. A policy that leaves women without maternity benefits and with higher out-of-pocket

costs than men seems at odds with broader public policy efforts to ensure adequate care during pregnancy and to protect low-income families' access to care.

To make tax credits work better for women, some have suggested that the federal government limit the extent to which rates charged within markets for insurance plans can vary by sex, age, or health characteristics. Attempts to do this in the individual market at the state level have had mixed results, however.[29] Some have also suggested that the imposition of minimum benefit standards or a requirement that health plans offer at least one standardized benefit plan would help guarantee access to benefits such as maternity care.[30] Other options suggested by researchers to improve the functioning of the individual market include the creation and subsidization of high-risk insurance pools and the involvement of the federal government as a reinsurer for people with health expenditures in the top 2 to 3 percent of the spending distribution.[31,32]

To avoid underwriting and premium variations by health and age, tax credits would probably work better for women and men if they were coupled with access to group policies that pool health risks across gender, age, and other characteristics.[33] This strategy would also address inherent inefficiencies in the individual market, in which administrative costs are estimated to account for 25 to 40 percent of each premium dollar, compared with 10 to 25 percent in the group market.[34] Therefore, targeting tax credits or premium assistance to the group rather than the individual market would most likely provide greater value on average for each tax credit dollar. A 2002 study by Jon Gabel found that, with the exception of healthy young men, both women and men are offered significantly less expensive coverage in the employer-sponsored group market than they are in the individual market.[35] Tax credits for use in the group market would need to be coupled with new options for low-income women and men to participate in group-rated plans.

Even if paired with group options, however, any tax credit or premium assistance based on flat rates would still encounter geographic variations in premiums and underlying health care costs. The variations observed in this 25-city study of the individual insurance market quite likely reflect underlying differences in provider fees and patterns of care across markets, the particular dynamics of the individual insurance market, and state variations in regulations affecting policies sold on an individual basis. Though policymakers may be able to make adjustments for sex or age or seek out group options, the dramatic regional price variations found in this study present a formidable challenge. The lack of distinct regional patterns in health plan costs means that there is no simple way

to provide flat-rate premium assistance that would buy a similar package of benefits for people with low incomes across the country.

APPENDIX

Table A-1a. Best Plans with Premiums of $1,000 or Less, Women Age 25

CITY, STATE	Annual Premium	Deductible*	O-O-P Limit	Life Max	Rx Benefit	Office Visit	Maternity	Mental Health
Atlanta, GA	$948	$5,000	$2,000	$2M	Covers 80%	Covers 80%	Not covered	Limited: $3,500 annual, $10,000 lifetime limit
Baltimore, MD	$858	$800	$2,000	$1M	Covers 75% after ded.; $500 limit	Covers 75% after ded.	Covers 75% after ded.	Limited
Cheyenne, WY	$984	$1,000	$1,000	$5M	Discount; 100% after ded.	$10 copay	Not covered	Limited: $3,500 annual, $10,000 lifetime limit
Chicago, IL	$1,008	$1,500	$4,500	$5M	$10/$25 copays	$30 copay	Not covered	Limited: $3,000/year limit
Cleveland, OH	$984	$1,000	$4,500	$3M	$150 ded.; $25/$35 copays	$45 copay	Optional	Limited: $3,000 lifetime cap
Denver, CO	$984	$1,000	$2,000	$3M		$45 copay	Optional	Limited: $3,000 lifetime cap
Des Moines, IA	$984	$1,000	$2,000	$3M	$150 ded.; $25/$35 copays	$45 copay	Optional	Limited: $3,000 lifetime cap
Detroit, MI	$936	$1,650	$1,650	$3M	Covers all after ded.	Covers all after ded.	Not covered	Not covered
Durham, NC	$996	$1,500	$3,500	$5M	Discount program	Selected copay	Not covered	Not covered
Hartford, CT	$984	$1,000	$2,000	$3M	Covers 80% after ded.	Covers 80% after ded.	Not covered	Same as any illness
Helena, MT	No plan available							
Houston, TX	$960	$2,000	$5,000	$5M	$200 ded.; $10/$25 copays	$30 copay	Not covered	Limited
Kansas City, KS	$1,008	$5,000	$6,000	$2M	$10/$20 copays	$20 copay	24-month waiting period	Limited: Covers 80%; $1,000 annual cap
Los Angeles, CA	$600	$500	$2,500	$6M	$100 ded.; $15/$35 copays	$20 copay	Not covered	For severe conditions only: $20 (2 visits/year)

CITY, STATE	Annual Premium	Deductible*	O-O-P Limit	Life Max	Rx Benefit	Office Visit	Maternity	Mental Health
Miami, FL	$852	$5,000	$5,000	$1M	Covers 75% after ded.	Covers 75% after ded.	Optional	Limited: $2,000 annual; $10,000 lifetime limit
Milwaukee, WI	$948	$2,500	$2,500	$5M	Discount; 100% after ded.	$10 copay	Not covered	Limited: $3,500 annual, $10,000 lifetime limit
Nashville, TN	$984	$2,500	$2,500	$5M	Discount; 100% after ded.	$10 copay	Not covered	Limited: $3,500 annual, $10,000 lifetime limit
New Orleans, LA	No plan available							
New York, NY**	No plan available							
Newark, NJ**	No plan available							
Philadelphia, PA	$948	$1,000	$2,000	$3M	Covers 80% after ded.	Covers 80% after ded.	Not covered	Same as any illness
Phoenix, AZ	$996	$1,650	$1,650	$3M	Covers all after ded.	Covers all after ded.	Not covered	Limited: $3,000 lifetime cap
Pierre, SD	$900	$2,500	$2,500	$5M	Discount; 100% after ded.	$25 copay	Not covered	Limited: $3,500 annual, $10,000 lifetime limit
Providence, RI	No plan available							
Seattle, WA	$960	$1,000	$2,000	$1M	Covers 50%	$15 copay	Covers 80% after ded.	Not covered
MEAN	**$941**	**$1,955**	**$2,840**					
MEDIAN	**$972**	**$1,500**	**$2,250**					

* In-network deductible.

** New York and New Jersey require health plans to charge the same rate for the same benefit package irrespective of age, sex, or health status.

Table A-1b. Best Plans with Premiums of $1,000 or Less, Women Age 35

CITY, STATE	Annual Premium	Deductible*	O-O-P Limit	Life Max	Rx Benefit	Office Visit	Maternity	Mental Health
Atlanta, GA	No plan available	No plan available						
Baltimore, MD	$927	$2,500	$2,500	$3M	Covers all after ded.	Covers all after ded.	Optional	Limited: $3,000 lifetime cap
Cheyenne, WY	$948	$2,500	$2,500	$5M	Discount; covers all after ded.	$25 copay	Not covered	Limited: $3,500 annual, $10,000 lifetime limit
Chicago, IL	$972	$5,000	$7,000	$5M	Discount program	Selected copay	Not covered	Not covered
Cleveland, OH	$972	$2,500	$1,000	$2.5M	$250 ded.; covers 80%	Covers all after ded.	Not covered	100%; 30 days/year cap
Denver, CO	$888	$2,500	$5,000	$3M	Covers all after ded.	Covers all after ded.	Not covered	Same as any illness
Des Moines, IA	$991	$2,500	$5,000	$3M	Covers all after ded.	Covers all after ded.	Optional	Limited: $3,000 lifetime cap
Detroit, MI	$972	$5,000	$7,000	$5M	Discount program	Selected copay	Not covered	Not covered
Durham, NC	$792	$5,000	$7,000	$5M	Discount program	Selected copay	Not covered	Not covered
Hartford, CT	$996	$2,500	$5,000	$3M	Covers all after ded.	Covers all after ded.	Not covered	Same as any illness
Helena, MT	No plan available							
Houston, TX	$888	$2,000	$3,000	5M	$200 ded.; $10/$25	$30 copay	Not covered	Not covered
Kansas City, KS	No plan available							
Los Angeles, CA	$924	$500	$2,500	$6M	$100 ded.; $15/$35 copays	$20 copay	Not covered	Limited
Miami, FL	No plan available							

CITY, STATE	Annual Premium	Deductible*	O-O-P Limit	Life Max	Rx Benefit	Office Visit	Maternity	Mental Health
Milwaukee, WI	$928	$5,000	$10,000	3M	Covers all after ded.	Covers all after ded.	Optional	Limited: $50/visit; $3,000 lifetime cap
Nashville, TN	$924	$5,000	$5,000	$5M	Discount; covers all after ded.	$10 copay	Not covered	Limited: $3,500 annual, $10,000 lifetime limit
New Orleans, LA	No plan available							
New York, NY**	No plan available							
Newark, NJ**	No plan available							
Philadelphia, PA	$924	$2,500	$2,500	$3M	Covers all after ded.	Covers all after ded.	Optional	Limited: $3,000 lifetime cap
Phoenix, AZ	$972	$5,000	$10,000	$3M	Covers all after ded.	Covers all after ded.	Optional	Limited: $3,000 lifetime cap
Pierre, SD	$840	$5,000	$5,000	$5M	Discount; covers all after ded.	$25 copay	Not covered	Limited: $3,500 annual, $10,000 lifetime limit
Providence, RI	No plan available							
Seattle, WA	$922	$2,500	$8,500	$2M	$500 ded.; tiered formulary	Covers 70% after ded.	Not covered	Not covered
MEAN	**$928**	**$3,382**	**$5,206**					
MEDIAN	**$927**	**$2,500**	**$5,000**					

* In-network deductible.

** New York and New Jersey require health plans to charge the same rate for the same benefit package irrespective of age, sex, or health status.

Table A-1c. Best Plans with Premiums of $1,000 or Less, Women Age 50

CITY, STATE	Annual Premium	Deductible*	O-O-P Limit	Life Max	Rx Benefit	Office Visit	Mental Health
Atlanta, GA	No plan available						No plan available
Baltimore, MD	$691	$10,000	$10,000	$1M	Covers 80% after ded.; $500 annual limit	Covers 80% after ded.	Limited
Cheyenne, WY	No plan available						
Chicago, IL	No plan available						
Cleveland, OH	$996	$5,000	$9,000	$5M	Discount program	$40 copay	Not covered
Denver, CO	No plan available						
Des Moines, IA	No plan available						
Detroit, MI	No plan available						
Durham, NC	No plan available						
Hartford, CT	No plan available						
Helena, MT	No plan available						
Houston, TX	No plan available						
Kansas City, KS	No plan available						
Los Angeles, CA	No plan available						
Miami, FL	No plan available						
Milwaukee, WI	No plan available						
Nashville, TN	No plan available						
New Orleans, LA	No plan available						
New York, NY**	No plan available						
Newark, NJ**	No plan available						
Philadelphia, PA	No plan available						
Phoenix, AZ	No plan available						
Pierre, SD	No plan available						
Providence, RI	No plan available						
Seattle, WA	No plan available						
MEAN	**$844**	**$7,500**	**$9,500**				
MEDIAN	**$844**	**$7,500**	**$9,500**				

* In-network deductible.

** New York and New Jersey require health plans to charge the same rate for the same benefit package irrespective of age, sex, or health status.

Table A-2a. Best Plans with Premiums of $1,000 or Less, Men Age 25

CITY, STATE	Annual Premium	Deductible*	O-O-P Limit	Life Max	Rx Benefit	Office Visit
Atlanta, GA	$972	$1,000	$2,000	$5M	$150 ded.; $15/$25/$40 copays	$20 copay
Baltimore, MD	$912	$750	$1,500	$3M	$100 ded.; $25/$35 copays	$35 copay
Cheyenne, WY	$828	$500	$1,500	$5M	Covers 80% after ded.	$10 copay
Chicago, IL	$936	$1,500	$3,500	$5M	Discount program	Selected copay
Cleveland, OH	$912	$500	$2,000	$2.5M	$250 ded.; covers 80%	$15 copay
Denver, CO	$996	$1,000	$4,000	$2M	$15/$40/$60 copays	$25 copay
Des Moines, IA	$852	$750	$1,500	$3M	$100 ded.; $25/$35 copays	$35 copay
Detroit, MI	$948	$1,000	$2,000	$3M	Covers 80% after ded.	Covers 80% after ded.
Durham, NC	$948	$500	$1,500	$5M	Discount card; covers all after ded.	$10 copay
Hartford, CT	$888	$750	$1,500	$3M	$100 ded.; $25/$35 copays	$35 copay
Helena, MT	$1,008	$5,000	$5,000	$5M	Discount card; covers all after ded.	Covers all after ded.
Houston, TX	$972	$1,500	$3,000	$5M	$150 ded.; $10/$25	$30 copay
Kansas City, KS	$996	$1,000	$2,000	$2M	$10/$30/$50 copays	$20 copay
Los Angeles, CA	$600	$500	$2,500	$6M	$100 ded.; $15/$30 copays	$20 copay
Miami, FL	$960	$1,500	$5,000	$2M	Covers 80%/60% after ded.	$20 copay
Milwaukee, WI	$960	$1,000	$2,000	$3M	$150 ded.; $25/$35 copays	$45 copay
Nashville, TN	$936	$1,000	$2,000	$5M	Discount card; covers all after ded.	$10 copay
New Orleans, LA	$900	$5,000	$5,000	$5M	Discount card; covers all after ded.	$10 copay
New York, NY**	No plan available					
Newark, NJ**	No plan available					
Philadelphia, PA	$936	$1,000	$2,000	$3M	Covers all after ded.	Covers all after ded.
Phoenix, AZ	$908	$750	$5,500	$5M	Discount program	Selected copay
Pierre, SD	$1,020	$500	$1,500	$5M	Discount card; 80% after ded.	$25 copay
Providence, RI	No plan available					
Seattle, WA	$960	$1,000	$2,000	$1M	Covers 50%	$15 copay
MEAN	**$925**	**$1,273**	**$2,659**			
MEDIAN	**$942**	**$1,000**	**$2,000**			

* In-network deductible only.

** New York and New Jersey require health plans to charge the same rate for the same benefit package irrespective of age, sex, or health status.

Table A-2b. Best Plans with Premiums of $1,000 or Less, Men Age 35

CITY, STATE	Annual Premium	Deductible*	O-O-P Limit	Life Max	Rx Benefit	Office Visit
Atlanta, GA	$984	$2,500	$2,000	$5M	$150 ded.; $15/$25/$40 copays	$20 copay
Baltimore, MD	$996	$1,500	$3,000	$3M	Covers all after ded.	Covers all after ded.
Cheyenne, WY	$984	$1,000	$1,000	$5M	Covers all after ded.	$10 copay
Chicago, IL	$792	$3,000	$5,000	$5M	$10 copay ($500 max)	$30 copay
Cleveland, OH	$948	$1,500	$2,000	$2.5M	$250 ded.; covers 80%	$15 copay
Denver, CO	$924	$1,500	$3,000	$3M	Covers all after ded.	Covers all after ded.
Des Moines, IA	$936	$1,500	$3,000	$3M	Covers all after ded.	Covers all after ded.
Detroit, MI	$912	$2,500	$5,000	$3M	Covers all after ded.	Covers all after ded.
Durham, NC	$996	$1,000	$2,000	$5M	Discount card; covers 100% after ded.	$10 copay
Hartford, CT	$967	$1,500	$3,000	$3M	Covers 80% after ded.	Covers 80% after ded.
Helena, MT	No plan available					
Houston, TX	$996	$2,000	$3,000	$5M	$200 ded.; $10/$25 copays	$30 copay
Kansas City, KS	$996	$2,500	$3,500	$2M	$10/$30/$50 copays	$20 copay
Los Angeles, CA	$924	$500	$2,500	$6M	$100 ded.; $15/$30 copays	$20 copay
Miami, FL	$840	$5,000	$5,000	$1M	Covers 75% after ded.	Covers 75% after ded.
Milwaukee, WI	$948	$2,500	$2,500	$5M	Covers all after ded.	$10 copay
Nashville, TN	$996	$2,500	$2,500	$5M	Discount card; covers all after ded.	$10 copay
New Orleans, LA	No plan available					
New York, NY**	No plan available					
Newark, NJ**	No plan available					
Philadelphia, PA	$972	$1,500	$3,000	$3M	Covers all after ded.	Covers all after ded.
Phoenix, AZ	$936	$2,500	$2,500	$2M	$15/$35/$50 copays	$25 copay
Pierre, SD	$900	$2,500	$2,500	$5M	Discount card; covers all after ded.	$25 copay
Providence, RI	No plan available					
Seattle, WA	$900	$2,500	$6,000	$2M	$500 ded.; covers 80%/70%/50%	Covers 30% after ded.
MEAN	**$942**	**$2,075**	**$3,100**			
MEDIAN	**$948**	**$2,250**	**$3,000**			

* In-network deductible only.

** New York and New Jersey require health plans to charge the same rate for the same benefit package irrespective of age, sex, or health status.

Table A-2c. Best Plans with Premiums of $1,000 or Less, Men Age 50

CITY, STATE	Annual Premium	Deductible*	O-O-P Limit	Life Max	Rx Benefit	Office Visit
Atlanta, GA	No plan available					
Baltimore, MD	$696	$10,000	$10,000	$1M	Covers 80% after ded.; $500 limit	Covers 80% after ded.
Cheyenne, WY	No plan available					
Chicago, IL	No plan available					
Cleveland, OH	No plan available					
Denver, CO	No plan available					
Des Moines, IA	No plan available					
Detroit, MI	No plan available					
Durham, NC	No plan available					
Hartford, CT	No plan available					
Helena, MT	No plan available					
Houston, TX	No plan available					
Kansas City, KS	No plan available					
Los Angeles, CA	No plan available					
Miami, FL	No plan available					
Milwaukee, WI	No plan available					
Nashville, TN	No plan available					
New Orleans, LA	No plan available					
New York, NY**	No plan available					
Newark, NJ**	No plan available					
Philadelphia, PA	No plan available					
Phoenix, AZ	No plan available					
Pierre, SD	No plan available					
Providence, RI	No plan available					
Seattle, WA	No plan available					
MEAN	**$696**	**$10,000**	**$10,000**			
MEDIAN	**$696**	**$10,000**	**$10,000**			

* In-network deductible only.

** New York and New Jersey require health plans to charge the same rate for the same benefit package irrespective of age, sex, or health status.

Table A-3a. Best Plans with Premiums of $1,500 or Less, Women Age 25

CITY, STATE	Annual Premium	Deductible*	O-O-P Limit	Life Max	Rx Benefit	Office Visit	Maternity	Mental Health
Atlanta, GA	$1,310	$750	$4,200	$3M	$100 ded.; $25/$35 copays	$35 copay	Optional	Limited: $3,000 lifetime cap
Baltimore, MD	$1,348	$500	$4,000	$3M	$100 ded.; $25/$35 copays	$35 copay	Not covered	Limited: $3,000 lifetime cap
Cheyenne, WY	$1,320	$250	$1,250	$5M	Discount; covers 80% after ded.	$10 copay	Not covered	Limited: $3,500 annual, $10,000 lifetime limit
Chicago, IL	$1,452	$750	$2,750	$5M	Discount program	Selected copay	Not covered	Not covered
Cleveland, OH	$1,308	$500	$2,000	$2.5M	$250 ded.; covers 80%	$15 copay	Not covered	Limited: 50% after ded.; 20 visits/year cap
Denver, CO	$1,416	$250	$1,500	$2M	$15/$40/$60 copays	$25 copay	Not covered	Limited: 50% of allowed charges
Des Moines, IA	$1,308	$500	$1,000	$3M	$100 ded.; $25/$35 copays	$35 copay	Not covered	Same as any illness
Detroit, MI	$1,452	$750	$2,750	$5M	Discount program	Selected copay	Not covered	Not covered
Durham, NC	$1,440	$500	$1,500	$5M	Discount card	$10 copay	Not covered	Limited: $3,500 annual, $10,000 lifetime limit
Hartford, CT	$1,368	$500	$1,000	$3M	$100 ded.; $25/$35 copays	$35 copay	Not covered	Same as any illness
Helena, MT	$1,380	$5,000	$5,000	$5M	Discount card	all after ded.	Not covered	Limited: $2,000/year cap; 21 days/year
Houston, TX	$1,392	$2,500	$2,500	$5M	Discount card	Selected copay	Not covered	If mandated by state
Kansas City, KS	$1,255	$2,500	$3,500	$2M	$10/$20 copays	$20 copay	After 24 months	Covers 80% after ded.; $1,000 annual cap
Los Angeles, CA	$1,260	$0	$4,500	$6M	$100 ded.; $10/$30 copays	$40 copay	Covers 40% after ded.	Limited

CITY, STATE	Annual Premium	Deductible*	O-O-P Limit	Life Max	Rx Benefit	Office Visit	Maternity	Mental Health
Miami, FL	$1,380	$1,500	$5,000	$2M	Covers 80% or 60% after ded.	$20 copay	Optional	Limited: $1,000 annual, $5,000 lifetime limit
Milwaukee, WI	$1,464	$500	$1,500	$5M	Discount; covers 80% after ded.	$25 copay	Not covered	Limited: $3,500 annual, $10,000 lifetime limit
Nashville, TN	$1,404	$500	$1,500	$5M	Discount card	$10 copay	Not covered	Limited: $3,500 annual, $10,000 lifetime limit
New Orleans, LA	No plan available							
New York, NY**	No plan available							
Newark, NJ**	No plan available							
Philadelphia, PA	$1,356	$500	$4,000	$3M	$100 ded.; $25/$35 copays	$35 copay	Not covered	Limited: $3,000 lifetime cap
Phoenix, AZ	$1,344	$500	$2,500	$5M	Discount program	Selected copay	Not covered	Not covered
Pierre, SD	$1,284	$500	$1,500	$5M	Discount; covers 80% after ded.	$25 copay	Not covered	Limited: $3,500 annual, $10,000 lifetime limit
Providence, RI	$1,428	$2,500	$2,500	$5M	Discount; 100% after ded.	$10 copay	Not covered	Limited: $3,500 annual, $10,000 lifetime limit
Seattle, WA	$1,044	$500	$2,000	$1M	Covers 50%	$15 copay	Covers 80% after ded.	Not covered
MEAN	**$1,351**	**$1,011**	**$2,634**					
MEDIAN	**$1,362**	**$500**	**$2,500**					

* In-network deductible.

** New York and New Jersey require health plans to charge the same rate for the same benefit package irrespective of age, sex, or health status.

Table A-3b. Best Plans with Premiums of $1,500 or Less, Women Age 35

CITY, STATE	Annual Premium	Deductible*	O-O-P Limit	Life Max	Rx Benefit	Office Visit	Maternity	Mental Health
Atlanta, GA	$1,464	$1,500	$1,500	$3M	Covers all after ded.	Covers all after ded.	Optional	Limited: $3,000 lifetime cap
Baltimore, MD	$1,470	$750	$4,250	$3M	$100 ded.; $25/$35	$35 copay	Optional	Limited: $3,000 lifetime cap
Cheyenne, WY	$1,356	$500	$1,500	$5M	Discount; covers 80% after ded.	$25 copay	Not covered	Limited: $3,500 annual, $10,000 lifetime limit
Chicago, IL	$1,488	$1,500	$3,500	$5M	Discount plan	Selected copay	Not covered	Not covered
Cleveland, OH	$1,452	$500	$2,000	$2.5M	$250 ded.; covers 80%	$15 copay	Not covered	Limited
Denver, CO	$1,416	$750	$3,500	$3M	$100 ded.; $25/$35 copays	$35 copay	Not covered	Same as any illness
Des Moines, IA	$1,416	$750	$3,500	$3M	$100 ded.; $25/$35 copays	$35 copay	Not covered	Same as any illness
Detroit, MI	$1,488	$1,500	$3,500	$5M	Discount plan	Selected copay	Not covered	Not covered
Durham, NC	$1,500	$750	$2,750	$5M	Discount plan	Selected copay	Not covered	Not covered
Hartford, CT	$1,476	$750	$3,500	$3M	$100 ded.; $25/$35 copays	$35 copay	Not covered	Same as any illness
Helena, MT	No plan available							
Houston, TX	$1,488	$1,500	$4,500	$5M	$150 ded.; $10/$25 copays	$30 copay	Not covered	Limited: $3,000 annual cap
Kansas City, KS	$1,157	$5,000	$6,000	$2M	$10/$20 copays	$20 copay	After 24 months	Limited
Los Angeles, CA	$924	$500	$2,500	$6M	$100 ded.; $15/$35 copays	$20 copay	Not covered	Limited
Miami, FL	$1,332	$5,000	$10,000	$1M	Covers 75% after ded.	Covers 75% after ded.	Optional	Limited: $2,000 annual, $10,000 lifetime limit

CITY, STATE	Annual Premium	Deductible*	O-O-P Limit	Life Max	Rx Benefit	Office Visit	Maternity	Mental Health
Milwaukee, WI	$1,368	$1,000	$2,000	$5M	Discount; covers 80% after ded.	$10 copay	Not covered	Limited: $3,500 annual, $10,000 lifetime limit
Nashville, TN	$1,428	$1,000	$2,000	$5M	Discount; covers 80% after ded.	$10 copay	Not covered	Limited: $3,500 annual, $10,000 lifetime limit
New Orleans, LA	No plan available							
New York, NY**	No plan available							
Newark, NJ**	No plan available							
Philadelphia, PA	$1,476	$750	$3,500	$3M	$100 ded.; $25/$35 copays	$35 copay	Not covered	Same as any illness
Phoenix, AZ	$1,464	$750	$2,750	$5M	Discount program	Selected copay	Not covered	Not covered
Pierre, SD	$1,296	$1,000	$2,000	$5M	Discount; covers 80% after ded.	$25 copay	Not covered	Limited: $3,500 annual, $10,000 lifetime limit
Providence, RI	$1,260	$5,000	$5,000	$5M	Discount; covers 100% after ded.	$10 copay	Not covered	Limited: $3,500 annual, $10,000 lifetime limit
Seattle, WA	$1,380	$1,000	$2,000	$1M	Covers 50%	$15 copay	Covers 80% after ded.	Not covered
MEAN	**$1,386**	**$1,512**	**$3,417**					
MEDIAN	**$1,428**	**$1,000**	**$3,500**					

*In-network deductible.

** New York and New Jersey require health plans to charge the same rate for the same benefit package irrespective of age, sex, or health status.

Table A-3c. Best Plans with Premiums of $1,500 or Less, Women Age 50

CITY, STATE	Annual Premium	Deductible*	O-O-P Limit	Life Max	Rx Benefit	Office Visit	Mental Health
Atlanta, GA	No plan available						
Baltimore, MD	$1,364	$2,500	$4,000	$1M	Covers 80% after ded.; $500 max	Covers 80% after ded.	Limited
Cheyenne, WY	$1,440	$2,500	$2,500	$5M	Discount; covers all after ded.	$10 copay	Limited: $3,500 annual, $10,000 lifetime limit
Chicago, IL	$1,236	$5,000	$9,000	$5M	Discount plan	Selected copay	Limited: outpatient only, as mandated by the state
Cleveland, OH	$1,476	$2,500	$5,000	2.5M	$250 ded.; covers 100%	Covers 80%	Limited
Denver, CO	No plan available						
Des Moines, IA	$1,308	$5,000	$5,000	$5M	Discount card; covers all after ded.	$10 copay	Limited: $3,500 annual, $10,000 lifetime limit
Detroit, MI	$1,236	$5,000	$9,000	$5M	Discount plan	Selected copay	Limited: outpatient only, or as mandated by state
Durham, NC	$1,224	$5,000	$7,000	$5M	Discount plan	Selected copay	Not covered
Hartford, CT	$1,392	$5,000	$10,000	$3M	Covers 80% after ded	Covers 80% after ded.	Same as any illness
Helena, MT	No plan available						
Houston, TX	$1,308	$5,000	$9,000	$5M	Discount plan	Selected copay	Limited: outpatient only, or as mandated by state
Kansas City, KS	No plan available						
Los Angeles, CA	$1,440	$1,000	$3,000	$6M	$100 ded.; $15/$35 copays	100% after O-O-P limit	Limited: Covers severe conditions only
Miami, FL	No plan available						

CITY, STATE	Annual Premium	Deductible*	O-O-P Limit	Life Max	Rx Benefit	Office Visit	Mental Health
Milwaukee, WI	$1,452	$5,000	$5,000	$5M	Covers all after ded.	$10 copay	Limited: $3,500 annual, $10,000 lifetime limit
Nashville, TN	$1,392	$5,000	$5,000	$5M	Discount plan	$10 copay	Limited: $3,500 annual, $10,000 lifetime limit
New Orleans, LA	No plan available						
New York, NY**	No plan available						
Newark, NJ**	No plan available						
Philadelphia, PA	$1,392	$5,000	$9,000	$5M	Discount plan	Selected copay	Limited: outpatient only, as mandated by the state
Phoenix, AZ	$1,320	$5,000	$7,000	$5M	Discount plan	Selected copay	Not covered
Pierre, SD	$1,272	$5,000	$5,000	$5M	Discount; covers all after ded.	$25 copay	Limited: $3,500 annual, $10,000 lifetime limit
Providence, RI	No plan available						
Seattle, WA	$1,332	$5,000	$6,000	$5M	$500 ded.; tiered formulary	Covers 70% after ded.	Not covered
MEAN	**$1,349**	**$4,281**	**$6,281**				
MEDIAN	**$1,348**	**$5,000**	**$5,500**				

* In-network deductible.

** New York and New Jersey require health plans to charge the same rate for the same benefit package irrespective of age, sex, or health status.

Table A-4a. Best Plans with Deductibles of $250 or Less, Women Age 25

CITY, STATE	Annual Premium	Deductible*	O-O-P Limit	Life Max	Rx Benefit	Office Visit	Maternity	Mental Health
Atlanta, GA	$3,358	$250	$1,250	$5M	Discount card; covers 80% after ded.	$10 copay	Not covered	Limited: $3,500 annual, $10,000 lifetime limit
Baltimore, MD	$1,918	$100	$1,000	$1M	Covers 80% after ded.; $500 annual limit	Covers 80% after ded.	Covers 80% after ded.	Limited
Cheyenne, WY	$1,320	$250	$1,250	$5M	Discount card; covers 80% after ded.	$10 copay	Not covered	Limited: $3,500 annual, $10,000 lifetime limit
Chicago, IL	$2,196	$0	$3,000	$5M	$10/$25 copays	$30 copay	Not covered	Limited
Cleveland, OH	$1,728	$250	$1,250	$5M	Discount card; covers 80% after ded.	$10 copay	Not covered	Limited: $3,500 annual, $10,000 lifetime limit
Denver, CO	$2,748	$250	$1,250	$5M	Discount card; covers 80% after ded.	Covers 80% after ded.	Not covered	Limited: $2,000 annual cap
Des Moines, IA	$1,800	$250	$1,250	$5M	Discount card; covers 80% after ded.	$10 copay	Not covered	Limited: $3,500 annual, $10,000 lifetime
Detroit, MI	$2,256	$250	$1,000	$5M	Covers 90% after ded.	$10/$20/$40 copays	Not covered	Limited: Covers 50%; $1,500 annual cap
Durham, NC	$1,524	$250	$1,250	$5M	Discount card; covers 80% after ded.	$10 copay	Not covered	Limited: $3,500 annual, $10,000 lifetime limit
Hartford, CT	$2,016	$250	$1,250	$5M	Discount card	$10 copay	Not covered	Same as any illness
Helena, MT	$2,748	$250	$1,250	$5M	Discount card	Covers 80% after ded.	Not covered	Limited: $2,000 annual limit
Houston, TX	$2,820	$250	$1,250	$5M	Discount card; covers 80% after ded.	$10 copay	Not covered	Limited: $3,500 annual, $10,000 lifetime limit
Kansas City, KS	$2,009	$500	$1,500	$2M	$10/$20 copays	$20 copay	After 24 months	Limited: $1,000 annual limit

CITY, STATE	Annual Premium	Deductible*	O-O-P Limit	Life Max	Rx Benefit	Office Visit	Maternity	Mental Health
Los Angeles, CA	$1,686	$0	$1,500	None	$10/$25 copays	$10 copay	100% after $1,000	Limited
Miami, FL	$2,112	$0	$1,500	None	$10/$20 copays	$10 copay	Not covered	Not covered
Milwaukee, WI	$1,728	$250	$1,250	$5M	Discount card; covers 80% after ded.	$10 copay	Not covered	Limited: $3,500 annual, $10,000 lifetime limit
Nashville, TN	$1,800	$250	$1,250	$5M	Discount card; covers 80% after ded.	$10 copay	Not covered	Limited: $3,500 annual, $10,000 lifetime limit
New Orleans, LA	$3,300	$250	$1,250	$5M	Discount card; covers 80% after ded.	$10 copay	Not covered	Limited: $3,500 annual, $10,000 lifetime limit
New York, NY**	$3,072	$250	$10,000	$1M	Not covered	$50 ded.; $10 copay	Covers 100%	Limited to 30 days/year
Newark, NJ**	$4,644	$0	None	None	Covers 50%	$10 copay	$100 copay; $1,000 limit	Limited: $1,000 annual limit
Philadelphia, PA	$1,956	$250	$1,250	$5M	Discount card; covers 80% after ded.	$10 copay	Not covered	Limited: $3,500 annual, $10,000 lifetime limit
Phoenix, AZ	$2,820	$0	$2,000	None	$10/$20 copays	$10 copay	Covers 80% of costs	Limited to 20 visits/year
Pierre, SD	$1,644	$250	$1,250	$5M	Discount card; covers 80% after ded.	$25 copay	Not covered	Limited: $3,500 annual, $10,000 lifetime limit
Providence, RI	$2,616	$250	$1,250	$5M	Discount card; covers 80% after ded.	$10 copay	Not covered	Limited: $3,500 annual, $10,000 lifetime limit
Seattle, WA	$1,584	$500	$1,500	$1M	$20 copay	Covers 80% after ded.	Covers 80% after ded.	Not covered
MEAN	**$2,296**	**$214**	**$1,740**					
MEDIAN	**$2,016**	**$250**	**$1,250**					

* In-network deductible.

** New York and New Jersey require health plans to charge the same rate for the same benefit package irrespective of age, sex, or health status.

Table A-4b. Best Plans with Deductibles of $250 or Less, Women Age 35

CITY, STATE	Annual Premium	Deductible*	O-O-P Limit	Life Max	Rx Benefit	Office Visit	Maternity	Mental Health
Atlanta, GA	$3,885	$250	$1,250	$5M	Discount card; covers 80% after ded.	$10 copay	Not covered	Limited: $3,500 annual, $10,000 lifetime limit
Baltimore, MD	$2,361	$100	$1,000	$1M	Covers 80% after ded.; $500 annual limit	Covers 80% after ded.	Covers 80% after ded.	Limited
Cheyenne, WY	$1,596	$250	$1,250	$5M	Discount card; covers 80% after ded.	$10 copay	Not covered	Limited: $3,500 annual, $10,000 lifetime limit
Chicago, IL	$3,144	$250	$1,000	$5M	$10/$20/$40 copays	Covers 90% after ded.	Not covered	Limited: Covers 50%; $500 annual limit
Cleveland, OH	$2,604	$250	$1,250	$5M	Discount card; covers 80% after ded.	$10 copay	Not covered	Limited: $3,500 annual, $10,000 lifetime limit
Denver, CO	$3,336	$250	$1,250	$5M	Discount card	Covers 80% after ded.	Not covered	Limited
Des Moines, IA	$2,064	$250	$1,250	$5M	Discount card; covers 80% after ded.	$10 copay	Not covered	Limited: $3,500 annual, $10,000 lifetime limit
Detroit, MI	$2,472	$250	$1,250	$5M	Discount card; covers 80% after ded.	$10 copay	Not covered	Limited: $3,500 annual, $10,000 lifetime limit
Durham, NC	$1,848	$250	$1,250	$5M	Discount card	Covers 80% after ded.	Not covered	Limited
Hartford, CT	$2,448	$250	$1,250	$5M	Discount card	$10 copay	Not covered	Same as any illness
Helena, MT	$3,372	$250	$1,250	$5M	Discount card	Covers 80% after ded.	Not covered	Limited
Houston, TX	$3,228	$250	$1,250	$5M	Discount card; covers 80% after ded.	$10 copay	Not covered	Limited: $3,500 annual, $10,000 lifetime limit
Kansas City, KS	$2,629	$500	$1,500	$2M	$10/$20 copays	$20 copay	After 24 months	Limited: Covers 80%; $1,000 annual limit

CITY, STATE	Annual Premium	Deductible*	O-O-P Limit	Life Max	Rx Benefit	Office Visit	Maternity	Mental Health
Los Angeles, CA	$1,885	None	$1,500	None	$10/$25 copays	$15 copay	Limited	Limited: 20 visits/year
Miami, FL	$2,172	None	$1,500	None	$10/$20 copays	$10 copay	Not covered	Not covered
Milwaukee, WI	$2,100	$250	$1,250	$5M	Discount card; covers 80% after ded.	$10 copay	Not covered	Limited: $3,500 annual, $10,000 lifetime limit
Nashville, TN	$2,376	$250	$1,250	$5M	Discount card; covers 80% after ded.	$25 copay	Not covered	Limited: $3,500 annual, $10,000 lifetime limit
New Orleans, LA	$4,008	$250	$1,250	$5M	Discount card; covers 80% after ded.	$10 copay	Not covered	Limited: $3,500 annual, $10,000 lifetime limit
New York, NY**	$3,072	$250	$10,000	$1M	Not covered	$50 ded.; $10 copay	Covers 100%	Limited: 30 days/year
Newark, NJ**	$4,644	None	None	None	Covers 50%	$10 copay	$100/day copay $1,000 limit	Limited: $1,000 annual limit
Philadelphia, PA	$2,376	$250	$1,250	$5M	Discount card; covers 80% after ded.	$10 copay	Not covered	Limited: $3,500 annual, $10,000 lifetime limit
Phoenix, AZ	$2,256	None	$2,000	None	$10/$20 copays	$10 copay	Limited	Limited: 20 visits/year
Pierre, SD	$1,992	$250	$1,250	$5M	Discount card; covers 80% after ded.	$25 copay	Not covered	Limited: $3,500 annual, $10,000 lifetime limit
Providence, RI	$2,988	$250	$1,250	$5M	Discount card; covers 80% after ded.	$10 copay	Not covered	Limited: $3,500 annual, $10,000 lifetime limit
Seattle, WA	$1,860	$500	$1,500	$1M	$20 copay	Covers 80% after ded.	Covers 80% after ded.	Not covered
MEAN	**$2,669**	**$267**	**$1,667**					
MEDIAN	**$2,448**	**$250**	**$1,250**					

* In-network deductible.

** New York and New Jersey require health plans to charge the same rate for the same benefit package irrespective of age, sex, or health status.

Table A-4c. Best Plans with Deductibles of $250 or Less, Women Age 50

CITY, STATE	Annual Premium	Deductible*	O-O-P Limit	Life Max	Rx Benefit	Office Visit	Mental Health
Atlanta, GA	$5,324	$250	$1,250	$5M	Discount card; covers 80% after ded.	$10 copay	Limited: $3,500 annual, $10,000 lifetime limit
Baltimore, MD	$3,736	$100	$1,000	$1M	Covers 80% after ded.; $500 annual limit	Covers 80% after ded.	Limited
Cheyenne, WY	$2,616	$250	$1,250	$5M	Discount card; covers 80% after ded.	$10 copay	Limited: $3,500 annual, $10,000 lifetime limit
Chicago, IL	$4,548	$250	$1,500	$5M	$10/$20/$40 copays	Covers 90% after ded.	Limited: Covers 50%; $500 annual limit
Cleveland, OH	$3,420	$250	$2,000	$2M	Covers 80% after ded.	$25 copay	Limited: $550 annual limit
Denver, CO	$5,460	$250	$1,250	$5M	Discount card; covers 80% after ded.	$10 copay	Limited: $3,500 annual, $10,000 lifetime limit
Des Moines, IA	$3,096	$250	$1,250	$5M	Discount card; covers 80% after ded.	$10 copay	Limited: $3,500 annual, $10,000 lifetime limit
Detroit, MI	$4,044	$250	$1,250	$5M	Discount card; covers 80% after ded.	$10 copay	Limited: $3,500 annual, $10,000 lifetime limit
Durham, NC	$3,024	$250	$1,250	$5M	Discount card; covers 80% after ded.	$10 copay	Limited: $3,500 annual, $10,000 lifetime limit
Hartford, CT	$4,008	$250	$1,250	$5M	Discount card; covers 80% after ded.	$10 copay	Limited: $3,500 annual, $10,000 lifetime limit
Helena, MT	$5,484	$250	$1,250	$5M	Discount card	Covers 80% after ded.	Limited
Houston, TX	$4,848	$250	$1,250	$5M	Discount card; covers 80% after ded.	$10 copay	Limited: $3,500 annual, $10,000 lifetime limit
Kansas City, KS	$3,548	$500	$1,500	$2M	$10/$20 copays	$20 copay	Limited: Covers 80%; $1,000 annual limit
Los Angeles, CA	$3,312	None	$1,500	None	$10/$25 copays	$15 copay	Limited: 20 visits/year
Miami, FL	$2,640	None	$1,500	None	$10/$20 copays	$10 copay	Not covered

CITY, STATE	Annual Premium	Deductible*	O-O-P Limit	Life Max	Rx Benefit	Office Visit	Mental Health
Milwaukee, WI	$3,432	$250	$1,250	$5M	Discount card; covers 80% after ded.	$10 copay	Limited: $3,500 annual, $10,000 lifetime limit
Nashville, TN	$3,300	$250	$1,250	$5M	Discount card; covers 80% after ded.	$10 copay	Limited: $3,500 annual, $10,000 lifetime limit
New Orleans, LA	$5,904	$250	$1,250	$5M	Discount card; covers 80% after ded.	$10 copay	Limited: $3,500 annual, $10,000 lifetime limit
New York, NY**	$3,072	$250	$10,000	$1M	Not covered	$50 ded.; $10 copay	Limited: 30 days/year
Newark, NJ**	$4,644	None	None	None	Covers 50%	$10 copay	Limited: $1,000 annual limit
Philadelphia, PA	$3,900	$250	$1,250	$5M	Discount card; covers 80% after ded.	$10 copay	Limited: $3,500 annual, $10,000 lifetime limit
Phoenix, AZ	$3,036	None	$2,000	None	$10/$20 copays	$10 copay	Limited: 20 visits/year
Pierre, SD	$3,012	$250	$1,250	$5M	Discount card; covers 80% after ded.	$10 copay	Limited: $3,500 annual, $10,000 lifetime limit
Providence, RI	$4,140	$250	$1,250	$5M	Discount card; covers 80% after ded.	$10 copay	Limited: $3,500 annual, $10,000 lifetime limit
Seattle, WA	$2,520	$500	$2,000	$1M	$20 copay	Covers 80% after ded.	Not covered
MEAN	**$3,843**	**$267**	**$1,740**				
MEDIAN	**$3,548**	**$250**	**$1,250**				

* In-network deductible.

** New York and New Jersey require health plans to charge the same rate for the same benefit package irrespective of age, sex, or health status.

NOTES

[1] R. J. Mills. *Current Population Reports*. Washington, DC: U.S. Census Bureau, September 2002.

[2] Council of Economic Advisors, Health Insurance Credits, February 14, 2002. The Administration proposal also includes tax credits for up to $3,000 per year for families with two or more children, with the credit phasing out at incomes between $25,000 and $60,000 for tax filers purchasing policies for more than one person.

[3] L. Duchon, C. Schoen, M. M. Doty, K. Davis, E. Strumpf, S. Bruegman. *Security Matters: How Instability in Health Insurance Puts U.S. Workers at Risk*. New York: The Commonwealth Fund, December 2001. Other research has shown that an average uninsured person has an annual income of $11,833. See S. Glied, C. Callahan, J. Mays, J. N. Edwards. *Bare-Bones Health Plans: Are They Worth the Money?* New York: The Commonwealth Fund, May 2002.

[4] Families USA. *A 10-foot Rope for a 40-foot Hole: Tax Credits for the Uninsured*. Washington, DC: Families USA, May 2002.

[5] B. Garret, L. M. Nichols, E. K. Greenman. *Workers Without Health Insurance: Who Are They and How Can Policy Reach Them?* Washington, DC: The Urban Institute, September 2001; B. Garret and J. Hudman. *Women Who Left Welfare: Health Care Coverage, Access, and Use of Health Services*. Washington, DC: Kaiser Commission on Medicaid and the Uninsured, June 2002.

[6] J. Lambrew. *Diagnosing Disparities in Health Insurance for Women: A Prescription for Change*. New York: The Commonwealth Fund, August 2001.

[7] Ibid.

[8] J. Gabel, K. Dhont, J. Pickreign. *Are Tax Credits Alone the Solution to Affordable Health Insurance? Comparing Individual and Group Insurance Costs in 17 U.S. Markets*. New York: The Commonwealth Fund, May 2002.

[9] L. Achman and D. Chollet. *Insuring the Uninsurable: An Overview of State High-Risk Pools*. New York: The Commonwealth Fund, August 2001.

[10] The study cities include Hartford, CT; Providence, RI; Baltimore, MD; Newark, NJ; New York, NY; Philadelphia, PA; Des Moines, IA; Chicago, IL; Kansas City, KS; Detroit, MI; Cleveland, OH; Pierre, SD; Milwaukee, WI; Phoenix, AZ; Los Angeles, CA; Denver, CO; Helena, MT; Seattle, WA; Cheyenne, WY; Miami, FL; Atlanta, GA; New Orleans, LA; Durham, NC; Nashville, TN; and Houston, TX.

[11] Families USA, May 2002; Henry J. Kaiser Family Foundation and Health Research and Educational Trust. *Employer Health Benefits, 2002 Annual Survey*. Menlo Park, CA and Chicago, IL: Henry J. Kaiser Family Foundation and Health Research and Educational Trust, 2002.

[12] R. B. Hackey. "The Politics of Reform," *Journal of Health Politics, Policy, and Law* vol. 25, no. 1 (2000):211–223; L. M. Nichols. "State Regulation: What Have We Learned So Far?" *Journal of Health Politics, Policy, and Law* vol. 25, no. 1 (2000):175–196.

[13] This figure does not include the additional costs of copays, coinsurance, or uncovered benefits.

[14] In addition, to be eligible for coverage, a woman's pregnancy must begin while the maternity benefits are in effect.

[15] Henry J. Kaiser Family Foundation and Health Research and Educational Trust, 2002.

[16] Families USA, May 2002.

[17] J. Hadley and J. D. Reschovsky. *Tax Credits and the Affordability of Individual Health Insurance*, Issue Brief no. 53. Washington, DC: Center for Studying Health System Change, July 2002.

[18] L. Ku and T. A. Coughlin. "Sliding Scale Premium Health Insurance Programs: Four States' Experiences," *Inquiry* vol. 36 (Winter 1999/2000):471–480; J. Hadley and J. D. Reschovsky, July 2002.

[19] L. Ku and T. A. Coughlin, Winter 1999/2000.

[20] Ibid.

[21] This analysis is based on the experience of sliding-scale premiums in public programs, which may not be entirely comparable to the experience of tax credits in the individual insurance market. However, the experience of the three states provides a reasonable example of the responsiveness of people with low-incomes to changes in insurance premiums.

[22] K. Pollitz, R. Sorian, K. A. Thomas. *How Accessible Is Individual Insurance for Consumers in Less-Than-Perfect Health?* Washington, DC: The Henry J. Kaiser Family Foundation, June 2001; K. Pollitz and R. Sorian. "Ensuring Health Security: Is the Individual Market Ready for Prime Time?" *Health Affairs* Web Exclusive (October 23, 2002):W372–376.

[23] J. Hadley and J. D. Reschovsky, July 2002.

[24] Commonwealth Fund Task Force on the Future of Health Insurance analysis of March 2001 Current Population Survey.

[25] S. K. Henshaw. "Unintended Pregnancy in the United States," *Family Planning Perspectives*, vol. 30, no. 1 (1998):24–29, 46.

[26] L. Ku and T. A. Coughlin, Winter 1999/2000.

[27] K. Pollitz, R. Sorian, and K. A. Thomas, June 2001; K. Pollitz and R. Sorian, October 23, 2002.

[28] Commonwealth Fund Task Force on the Future of Health Insurance analysis of March 2001 Current Population Survey.

[29] R. B. Hackey, 2000; L. M. Nichols, 2000; M. V. Pauly and L. M. Nichols. "The Nongroup Health Insurance Market: Short on Facts, Long on Opinions and Policy Disputes," *Health Affairs* Web Exclusive (October 23, 2002):W325–344.

[30] L. Tollen, R. M. Crane, R. Liu, and S. Zatkin. "The Nongroup Market as One Element of a Broader Coverage-Expansion Strategy," *Health Affairs* Web Exclusive (October 23, 2002):W383–386.

[31] B. Abbe. "Using Tax Credits and State High-Risk Pools to Expand Health Insurance Coverage," *Health Affairs* Web Exclusive (October 23, 2002):W345–348; D. Chollet. "Expanding Individual Health Insurance Coverage: Are High-Risk Pools the Answer?" *Health Affairs* Web Exclusive (October 23, 2002):W349–352.

[32] K. Swartz. "Government as Reinsurer for Very-High-Cost Persons in Nongroup Health Insurance Markets," *Health Affairs* Web Exclusive (October 23, 2002):W380–382.

[33] S. Glied. *Challenges and Options for Increasing the Number of Americans with Health Insurance*. New York: The Commonwealth Fund, December 2000; S. Glied et al. "Strategies to Expand Health Insurance for Working Americans," *Inquiry* vol. 38, no. 2 (Summer 2001); R. Cunningham. "Joint Custody: Bipartisan Interest Expands Scope of Tax-Credit Proposals," *Health Affairs* Web Exclusive (September 18, 2002):W290–298.

[34] J. Gabel et al. "Individual Insurance: How Much Financial Protection Does it Provide?" *Health Affairs* Web Exclusive (April 17, 2002):W172–181.

[35] J. Gabel, K. Dhont, and J. Pickreign. *Are Tax Credits Alone the Solution to Affordable Health Insurance? Comparing Individual and Group Insurance Costs in 17 U.S. Markets*. New York: The Commonwealth Fund, May 2002.

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Medicaid Coverage for the Working Uninsured: The Role of State Policy (November/December 2002). Randall R. Bovbjerg, Jack Hadley, Mary Beth Pohl, and Marc Rockmore. *Health Affairs,* vol. 21, no. 6. Copies are available from *Health Affairs,* 7500 Old Georgetown Road, Suite 600, Bethesda, MD 20814-6133, Tel: 301-656-7401 ext. 200, Fax: 301-654-2845. Available online at http://www.healthaffairs.org/readeragent.php?ID=/usr/local/apache/sites/healthaffairs.org/htdocs/Library/v21n6/s34.pdf.

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The Perils of Buying Your Own Policy (September 2002, Web exclusive). Trudy Lieberman. *Consumer Reports.* Available in the Consumer Advice section of www.consumerreports.com.

#559 *The Erosion of Employer-Based Health Coverage and the Threat to Workers' Health Care* (August 2002). Jennifer N. Edwards, Michelle M. Doty, and Cathy Schoen. Based on a Commonwealth Fund survey of health insurance in the workplace, this issue brief finds that two of five workers experienced increases in their premiums or cost-sharing, or both, during 2001. Although public support for job-based health insurance remains strong, many workers are not confident that employers will continue to offer coverage to them down the road. Workers are even more uncertain about their ability to get good health care in the future.

Health Insurance Expansions for Working Families: A Comparison of Targeting Strategies (July/August 2002). Danielle H. Ferry, Bowen Garrett, Sherry Glied, Emily K. Greenman, and Len M. Nichols. *Health Affairs,* vol. 21, no. 4. Copies are available from *Health Affairs,* 7500 Old Georgetown Road, Suite 600, Bethesda, MD 20814-6133, Tel: 301-656-7401 ext. 200, Fax: 301-654-2845. Available online at http://www.healthaffairs.org/readeragent.php?ID=/usr/local/apache/sites/healthaffairs.org/htdocs/Library/v21n4/s33.pdf.

The Unraveling of Health Insurance (July 2002, Web exclusive). Trudy Lieberman. *Consumer Reports.* Available in the Consumer Advice section of www.consumerreports.com.

#509 *Family Out-of-Pocket Spending for Health Services: A Continuing Source of Financial Insecurity* (June 2002). Mark Merlis. This report examines trends in out-of-pocket spending, the components of that spending, and the characteristics of families with high out-of-pocket costs.

#556 *Do Enrollees in 'Look-Alike' Medicaid and SCHIP Programs Really Look Alike?* (May/June 2002). Jennifer N. Edwards, Janet Bronstein, and David B. Rein. *Health Affairs,* vol. 21, no. 3. In their analysis of Georgia's similar-looking Medicaid and SCHIP programs, the authors present three possible explanations for the differences in access to care between the two populations: Medicaid families are less familiar with and supportive of systems requiring use of an assigned primary care physician, the families face more nonprogram barriers to using care, and physicians have different responses to the two programs.

#527 *Are Tax Credits Alone the Solution to Affordable Health Insurance? Comparing Individual and Group Insurance Costs in 17 U.S. Markets* (May 2002). Jon R. Gabel, Kelley Dhont, and Jeremy Pickreign, Health Research and Educational Trust. This report identifies solutions that might make tax credits and the individual insurance market work. These include raising the amount of the tax credits; adjusting the credit according to age, sex, and health status; and combining tax credits with new access to health coverage through existing public or private group insurance programs.

#518 *Bare-Bones Health Plans: Are They Worth the Money?* (May 2002). Sherry Glied, Cathi Callahan, James Mays, and Jennifer N. Edwards. This issue brief finds that a less-expensive health insurance product would leave low-income adults at risk for high out-of-pocket costs that could exceed their annual income. The authors conclude that a safeguard similar to that provided by the State Children's Health Insurance Program (CHIP)—a spending cap of 5 percent of annual income for low-income families—would be needed in conjunction with any move toward a stripped-down benefit package.

#540 *Individual Insurance: How Much Financial Protection Does It Provide?* (April 17, 2002). Jon R. Gabel, Kelley Dhont, Heidi Whitmore, and Jeremy Pickreign, Health Research and Educational Trust. *Health Affairs* Web Exclusive. This article demonstrates that a $1,000 tax credit would be more than adequate to buy individual coverage for healthy, young, single males, but it would not even come close for their middle-aged peers. Article available online only at www.healthaffairs.org/WebExclusives/Gabel_Web_Excl_041702.htm.

#506 *Erosion of Private Health Insurance Coverage for Retirees: Findings from the 2000 and 2001 Retiree Health and Prescription Drug Coverage Survey* (April 2002). The Henry J. Kaiser Family Foundation, Health Research and Educational Trust, and The Commonwealth Fund. The survey profiles retiree health coverage for Medicare-age (65+) retirees, including the amount retirees pay for coverage compared to active workers, cost-sharing for prescription drugs, and eligibility requirements for retiree benefits. Available online only at www.cmwf.org.

#521 *Work in America: New Challenges for Health Care* (April 2002). Karen Davis. In this essay—a reprint of the president's message from the Fund's *2001 Annual Report*—the author examines trends in the U.S. labor force over the past quarter century and how they affect health, health care, and health insurance coverage.

#508 *E-Health Options for Business: Evaluating the Choices* (March 2002). Sharon Silow-Carroll and Lisa Duchon. In this field report, the authors say that e-health tools—new Internet-based products that some employers and employees are now using to manage health benefits—have the potential to provide greater control to consumers and lower overall costs for administering benefits. The authors warn, however, that employees may face increased financial burdens as health care costs

rise faster than employer contributions, and that adverse risk selection could raise costs and limit choice for some employees.

Pricing the Priceless: A Health Care Conundrum (2002). Joseph P. Newhouse. The book presents a study of medical care pricing and its social, political, and economic consequences. Copies are available from The MIT Press, c/o Triliteral, 100 Maple Ridge Drive, Cumberland, RI 02864, Tel: 800-405-1619, Fax: 800-406-9145, E-mail: mitpress-orders@mit.edu.

#512 *Security Matters: How Instability in Health Insurance Puts U.S. Workers at Risk* (December 2001). Lisa Duchon, Cathy Schoen, Michelle M. Doty, Karen Davis, Erin Strumpf, and Stephanie Bruegman. This report, based on The Commonwealth Fund 2001 Health Insurance Survey, finds that in the past year one of four Americans ages 19 to 64—some 38 million adults—was uninsured for all or part of the time. Lapses in coverage often restrict people's access to medical care, cause problems in paying medical bills, and even make it difficult to afford basic living costs such as food and rent.

#513 *Maintaining Health Insurance During a Recession: Likely COBRA Eligibility* (December 2001). Michelle M. Doty and Cathy Schoen. This issue brief, based on The Commonwealth Fund 2001 Health Insurance Survey, examines the potential as well as limits of COBRA eligibility as a strategy for protecting workforce access to affordable health care benefits.

#514 *Experiences of Working-Age Adults in the Individual Insurance Market* (December 2001). Lisa Duchon and Cathy Schoen. This issue brief, based on The Commonwealth Fund 2001 Health Insurance Survey, describes the difficulties faced by those without access to group health coverage in obtaining adequate, affordable individual health insurance.

#478 *Universal Coverage in the United States: Lessons from Experience of the 20th Century* (December 2001). Karen Davis. This issue brief, adapted from an article in the March 2001 *Journal of Urban Health: Bulletin of the New York Academy of Medicine,* traces how the current U.S. health care system came to be, how various proposals for universal health coverage gained and lost political support, and what the pros and cons are of existing alternatives for expanding coverage.

#511 *How the Slowing U.S. Economy Threatens Employer-Based Health Insurance* (November 2001). Jeanne M. Lambrew, George Washington University. This report documents the link between loss of health insurance and unemployment, estimating that 37 percent of unemployed people are uninsured—nearly three times as high as the uninsured rate for all Americans (14%). The jobless uninsured are at great financial risk should they become ill or injured.

#475 *Business Initiatives to Expand Health Coverage for Workers in Small Firms* (October 2001). Jack A. Meyer and Lise S. Rybowski. This report weighs the problems and prospects of purchasing coalitions formed by larger businesses to help small firms expand access to health insurance. The authors say that private sector solutions alone are unlikely to solve the long-term problem, and the public sector will need to step in to make health insurance more affordable to small businesses.

Managed Care and Market Power: Physician Organizations in Four Markets (September/October 2001). Meredith B. Rosenthal, Bruce E. Landon, and Haiden A. Huskamp. *Health Affairs,* vol. 20, no. 5. Copies are available from *Health Affairs,* 7500 Old Georgetown Road, Suite 600, Bethesda, MD 20814-6133, Tel: 301-656-7401 ext. 200, Fax: 301-654-2845, www.healthaffairs.org.

#502 *Gaps in Health Coverage Among Working-Age Americans and the Consequences* (August 2001). Catherine Hoffman, Cathy Schoen, Diane Rowland, and Karen Davis. *Journal of Health Care for the Poor and Underserved,* vol. 12, no. 3. In this article, the authors examine health coverage and access

to care among working-age adults using the Kaiser/Commonwealth 1997 National Survey of Health Insurance, and report that having even a temporary gap in health coverage made a significant difference in access to care for working-age adults.

#493 *Diagnosing Disparities in Health Insurance for Women: A Prescription for Change* (August 2001). Jeanne M. Lambrew, George Washington University. In this report, the author concludes that building on insurance options that currently exist—such as employer-sponsored insurance, the Children's Health Insurance Program (CHIP), and Medicaid—represents the most targeted and potentially effective approach for increasing access to affordable coverage for the nation's 15 million uninsured women.

#472 *Insuring the Uninsurable: An Overview of State High-Risk Health Insurance Pools* (August 2001). Lori Achman and Deborah Chollet, Mathematica Policy Research, Inc. The authors argue that high premiums, deductibles, and copayments make high-risk pools unaffordable for people with serious medical conditions, and suggest that by lifting the tax exemption granted to self-insured plans, states could provide their high-risk pools with some much-needed financing.

#469 *Embraceable You: How Employers Influence Health Plan Enrollment* (July/August 2001). Jon Gabel, Jeremy Pickreign, Heidi Whitmore, and Cathy Schoen. *Health Affairs,* vol. 20, no. 4. In this article, the authors reveal that high employee contributions for health insurance often deter low-income workers from signing up for coverage, even when they are eligible.

#468 *Market Failure? Individual Insurance Markets for Older Americans* (July/August 2001). Elisabeth Simantov, Cathy Schoen, and Stephanie Bruegman. *Health Affairs,* vol. 20, no. 4. This study shows that adults ages 50 to 64 who buy individual coverage are likely to pay much more out-of-pocket for a limited package of benefits than their counterparts who are covered via their employers.

#457 *Health Insurance on the Way to Medicare: Is Special Government Assistance Warranted?* (July 2001). Pamela Farley Short, Dennis G. Shea, and M. Paige Powell, The Pennsylvania State University. The authors conclude that the loss of employer insurance should not be used as the primary justification for implementing Medicare buy-in or other reforms for over-55 and over-62 age groups, but instead propose that the better justification for such reforms is the poorer average health status of those nearing age 65.

#488 *Inquiry* (Summer 2001). Vol. 38, no. 2. Articles based on the 10-report series *Strategies to Expand Health Insurance for Working Americans,* which was released by the Fund in December 2000 and is available online at www.cmwf.org.

#449 *How the New Labor Market Is Squeezing Workforce Health Benefits* (June 2001). James L. Medoff, Howard B. Shapiro, Michael Calabrese, and Andrew D. Harless, Center for National Policy. To understand how labor market trends have contributed to the decline in the proportion of private-sector workers receiving benefits from their own employers—and to anticipate future trends—this study examines changes over a 19-year period, 1979 to 1998.

#487 *Women's Health Issues* (May/June 2001). Vol. 11, no. 3. Entire journal issue devoted to new analysis of The Commonwealth Fund 1998 Survey of Women's Health.

#464 *Health Insurance: A Family Affair—A National Profile and State-by-State Analysis of Uninsured Parents and Their Children* (May 2001). Jeanne M. Lambrew, George Washington University. This report suggests that expanding Medicaid and State Children's Health Insurance Program (CHIP) coverage to parents as well as children may not only decrease the number of uninsured Americans but may be the best way to cover more uninsured children.

#453 *Running in Place: How Job Characteristics, Immigrant Status, and Family Structure Keep Hispanics Uninsured* (May 2001). Claudia L. Schur and Jacob Feldman, Project HOPE Center for Health Affairs. This report looks at factors that influence health insurance coverage for Hispanics, the fastest-growing minority population in the United States. The analysis shows that characteristics of employment account for much, but not all, of the problem. Family structure seems to play some role, as does immigrant status, which affects Hispanic immigrants more than other groups.

Preparing for the Future: A 2020 Vision for American Health Care (April 2001). Karen Davis. *Academic Medicine,* vol. 76, no. 4. Copies are available from Karen Davis, President, The Commonwealth Fund, 1 East 75th Street, New York, NY 10021-2692.

#462 *Expanding Public Programs to Cover the Sick and Poor Uninsured* (March 2001). Karen Davis. In invited testimony before the Senate Finance Committee, the Fund's president presented a compelling case for expanding existing public health insurance programs to provide coverage for the most vulnerable segments of the nation's 42.6 million uninsured. She stressed the importance of expanding Medicaid and the Children's Health Insurance Program (CHIP) to cover parents of covered children.

#441 *Medicare Buy-In Options: Estimating Coverage and Costs* (March 2001). John Sheils and Ying-Jun Chen, The Lewin Group, Inc. This paper examines the need for insurance expansions for Americans approaching retirement age and analyzes the likely impact of Medicare buy-in options on program costs and their effectiveness in reducing the numbers of uninsured.

Universal Coverage in the United States: Lessons from Experience of the 20th Century (March 2001). Karen Davis. *Journal of Urban Health: Bulletin of the New York Academy of Medicine,* vol. 78, no. 1. Copies are available from the New York Academy of Medicine, 1216 Fifth Avenue, New York, NY 10029-5293.

#445 *Expanding Employment-Based Health Coverage: Lessons from Six State and Local Programs* (February 2001). Sharon Silow-Carroll, Emily K. Waldman, and Jack A. Meyer, Economic and Social Research Institute. As with publication **#424** (see below), this report describes the various ways states and local communities are making coverage more affordable and accessible to the working uninsured, but looks more closely at programs in six of the states discussed in the earlier report.

#459 *Betwixt and Between: Targeting Coverage Reforms to Those Approaching Medicare* (January/February 2001). Dennis G. Shea, Pamela Farley Short, and M. Paige Powell. *Health Affairs,* vol. 20, no. 1. The article examines whether eligibility for a Medicare buy-in should be based on age or ability to pay.

#439 *Patterns of Insurance Coverage Within Families with Children* (January/February 2001). Karla L. Hanson. *Health Affairs,* vol. 20, no. 1. Using the 1996 Medical Expenditure Panel Survey, this article examines patterns of health insurance within families with children, determining that 3.2 million families are uninsured and another 4.5 million families are only partially insured.

How a Changing Workforce Affects Employer-Sponsored Health Insurance (January/February 2001). Gregory Acs and Linda J. Blumberg. *Health Affairs,* vol. 20, no. 1. Copies are available from *Health Affairs,* 7500 Old Georgetown Road, Suite 600, Bethesda, MD 20814-6133, Tel: 301-656-7401 ext. 200, Fax: 301-654-2845, www.healthaffairs.org.

#415 *Challenges and Options for Increasing the Number of Americans with Health Insurance* (January 2001). Sherry A. Glied, Joseph A. Mailman School of Public Health, Columbia University. This

overview paper summarizes the 10 option papers written as part of the series Strategies to Expand Health Insurance for Working Americans.

#442 *Incremental Coverage Expansion Options: Detailed Table Summaries to Accompany Option Papers Commissioned by The Commonwealth Fund Task Force on the Future of Health Insurance* (January 2001). Sherry A. Glied and Danielle H. Ferry, Joseph L. Mailman School of Public Health, Columbia University. This paper, a companion to publication **#415,** presents a detailed side-by-side look at the 10 option papers in the series Strategies to Expand Health Insurance for Working Americans.

#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. Available online only at www.cmwf.org.

#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. Available online only at www.cmwf.org.

#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. Available online only at www.cmwf.org.

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

#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. Available online only at www.cmwf.org.

#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. Available online only at www.cmwf.org.

#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. Available online only at www.cmwf.org.

#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 policymakers 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. Available online only at www.cmwf.org.

#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. Available online only at www.cmwf.org.

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

#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.

#438 *A 2020 Vision for American Health Care* (December 11/25, 2000). Karen Davis, Cathy Schoen, and Stephen Schoenbaum. *Archives of Internal Medicine,* vol. 160, no. 22. The problem of nearly 43 million Americans without health insurance could be virtually eliminated in a single generation through a health plan based on universal, automatic coverage that allows choice of plan and provider. The proposal could be paid for, according to Fund President Davis and coauthors, by using the quarter of the federal budget surplus which results from savings in Medicare and Medicaid.

#476 *"Second-Generation" Medicaid Managed Care: Can It Deliver?* (Winter 2000). Marsha Gold and Jessica Mittler, Mathematica Policy Research, Inc. *Health Care Financing Review,* vol. 22, no. 2. This study of Medicaid managed care programs in seven states finds that the programs require state policymakers to make difficult trade-offs among the competing goals of improving Medicaid access, providing care for the uninsured, and serving those with special needs who are dependent on state-funded programs. Available online only at www.cmwf.org.

Medicaid's Complex Goals: Challenges for Managed Care and Behavioral Health (Winter 2000). Marsha Gold and Jessica Mittler, Mathematica Policy Research, Inc. *Health Care Financing Review,* vol. 22, no. 2. Copies are available from Marsha Gold, Mathematica Policy Research, Inc., 600 Maryland Avenue, SW, Suite 550, Washington, DC 20024, E-mail: MGold@mathematica-mpr.com.

Tracking Health Care Costs: Inflation Returns (November/December 2000). Christopher Hogan, Paul B. Ginsburg, and Jon R. Gabel. *Health Affairs,* vol. 19, no. 6. Copies are available from *Health Affairs,* 7500 Old Georgetown Road, Suite 600, Bethesda, MD 20814-6133, Tel: 301-656-7401 ext. 200, Fax: 301-654-2845, www.healthaffairs.org.

#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 supersedes state laws that relate to private-sector, employer-sponsored plans.

Customizing Medicaid Managed Care—California Style (September/October 2000). Debra A. Draper and Marsha Gold. *Health Affairs,* vol. 19, no. 5. Copies are available from *Health Affairs,* 7500 Old Georgetown Road, Suite 600, Bethesda, MD 20814-6133, Tel: 301-656-7401 ext. 200, Fax: 301-654-2845, www.healthaffairs.org.

#412 *Living Longer, Staying Well: Promoting Good Health for Older Women* (September 2000). Karen Scott Collins and Erin Strumpf. In this issue brief based on a new analysis of The Commonwealth Fund 1998 Survey of Women's Health, the authors provide insight into the gaps in preventive care that currently exist and the disparities in access to care found between lower- and higher-income older women.

Inadequate Health Insurance: Costs and Consequences (August 11, 2000). Karen Donelan, Catherine M. DesRoches, and Cathy Schoen. *Medscape General Medicine*. Available online at www.medscape.com/ Medscape/GeneralMedicine/journal/public/mgm.journal.html.

#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.

#406 *Counting on Medicare: Perspectives and Concerns of Americans Ages 50 to 70* (July 2000). Cathy Schoen, Elisabeth Simantov, Lisa Duchon, and Karen Davis. This full report of findings from 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.

#385 *State Experiences with Cost-Sharing Mechanisms in Children's Health Insurance Expansions* (May 2000). Mary Jo O'Brien et al. This report examines the effect of cost-sharing on participation in the State Child Health Insurance Program (CHIP).

#384 *State Experiences with Access Issues Under Children's Health Insurance Expansions* (May 2000). Mary Jo O'Brien et al. This report explores how the design and administration of state incremental insurance expansions affect access to health insurance coverage and, ultimately, access to all health care services.

#429 *Role of Insurance in Promoting Access to Care—Uninsured and Unstably Insured: The Importance of Continuous Coverage* (April 2000). Cathy Schoen and Catherine M. DesRoches. *HSR: Health Services Research,* vol. 35, part II. Using data from three different survey databases, the authors report that, compared with those continuously insured, those insured but with a recent time uninsured are two to three times as likely to report access problems.

#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 9 million of the country's 11 million uninsured Hispanics are in working families, and the effect that lack has on the Hispanic community.

#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.

#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.

#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.

#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.

Women's Health and Managed Care (2000). Karen Davis, Cathy Schoen, and Karen Scott Collins. This chapter from the book *Women and Health* reviews what is currently known about the effectiveness of managed care in addressing women's health concerns and presents new information about women's experiences obtaining health care in the evolving marketplace. Copies of the book are available from Academic Press, 525 B Street, Suite 1900, San Diego, CA 92101-4495, Tel: 800-321-5068.

#379 *Health Care Access and Coverage for Women: Changing Times, Changing Issues?* (November 1999). Deborah Lewis-Idema, Joan M. Leiman, Jane E. Meyer, and Karen Scott Collins. This policy report of The Commonwealth Fund Commission on Women's Health examines current trends in health care coverage, especially the growth of managed care, and how these trends affect women's access to care.

#347 *Can't Afford to Get Sick: A Reality for Millions of Working Americans* (September 1999). John Budetti, Lisa Duchon, Cathy Schoen, and Janet Shikles. This report from The Commonwealth Fund 1999 National Survey of Workers' Health Insurance finds that millions of working Americans are struggling to get the health care they need because they lack insurance or experience gaps in coverage.

#332 *Health Concerns Across A Woman's Lifespan: The Commonwealth Fund 1998 Survey of Women's Health* (May 1999). Karen Scott Collins, Cathy Schoen, Susan Joseph, Lisa Duchon, Elisabeth Simantov, and Michele Yellowitz. This wide-ranging survey on women's health highlights key findings and serves as an update to a similar survey conducted by The Commonwealth Fund Commission on Women's Health in 1993. The survey finds that in the past five years women and their physicians appear to be more aware of steps that can be taken to assure healthy and productive lives, but progress toward promoting various health behaviors has been uneven.