ARE TAX CREDITS ALONE THE SOLUTION TO AFFORDABLE HEALTH INSURANCE?

COMPARING INDIVIDUAL AND GROUP INSURANCE COSTS IN 17 U.S. MARKETS

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CONTENTS

LIST OF EXHIBITS

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EXECUTIVE SUMMARY

The number of Americans without health insurance is near an all-time high, and various legislative proposals in Congress over the past few years have made little headway in reducing the number or uninsured. Now, congressional Democrats and Republicans, as well as the Bush administration, are sponsoring legislation that would allow individuals to receive tax credits toward buying health insurance. This paper addresses the affordability of individual coverage under such a system of tax credits. First, we compare group and individual insurance premium costs in 16 metropolitan areas and one rural area in the United States for individual plans that are roughly comparable to average benefits in the employer group market. Second, we assess the affordability of individual insurance premiums for two age groups—males and females ages 27 and 55—with no preexisting medical conditions whose annual income is 200 percent of the poverty threshold. We look at premiums relative to incomes assuming these individuals receive a $1,500 tax credit. About two-thirds of those presently uninsured are from families with incomes at less than 200 percent of the poverty level.

We drew data for the group market rates from average rates of employer-based health insurance obtained in the 2001 Kaiser Family Foundation/Health Research and Educational Trust (KFF/HRET) 2001 Survey of Employer-Sponsored Health Benefits and similar state surveys in California and Iowa. For the analysis, we included those metropolitan areas and selected rural areas with at least 20 employers participating in the survey. In each of these markets, we calculated average group rates to compare with individual insurance premiums in the same market. Data on individual insurance premiums were obtained from two e-health websites—E-Health Insurance and Quotesmith—for the 17 market area comparisons. To compare premium rates for a roughly similar scope of benefits, the study specified a range of benefits and patient cost-sharing in the individual market that was as close as possible to the median prevailing in the employer group market.

FINDINGS

Employer group insurance offered coverage that was substantially less expensive than that in the individual market for all but young, healthy males. For 27-year-old males, the median premium of $2,136 in the 17 markets was 22 percent less than the group insurance median, and young healthy male rates were below group rates in all but one market. For 27-year-old females, however, the median premium of $2,880 was 5 percent higher than the corresponding figure for the group insurance market, even though the premium quoted did not include maternity benefits.

Individual market rates for older adults, even those with no health conditions, were substantially above the group rates in all 17 markets. Both 55-year-old males and females always received premium quotes that exceeded the average premium for group plans. The median quote for a healthy 55-year-old male was $6,120 and for a healthy 55-year-old female it was $6,108, more than twice the cost of group health insurance.

Although the analysis sought to compare similar benefits plans, on closer examination the employer group plans in each market usually offered fewer benefit limits and less cost-sharing. Cost-sharing rates tended to be lower for in-network and out-of-network coverage. Moreover, all group plans included maternity benefits. These were available in the study markets for individual plans only by paying for an extra premium rider.

Tax credits will not make individual health insurance affordable for healthy 55-year-old people. Even with a $1,500 tax credit, low-income 55-year-old males and females would pay one-fourth or more of their income toward health insurance to receive benefits close to those prevailing in employer plans. There were no instances in which the assumed tax credit alleviated the entire financial burden of individuals in this age group. In contrast, in eight of the markets examined, a 27-year-old-male would pay nothing or very little (1% or less of income) for health insurance with a tax credit of $1,500. In four of the 17 markets, rates after the credit would equal or exceed 6 percent of income for young, healthy males. In nine of the 17 markets, healthy 27-year-old females would pay 8 percent or more of income for the same benefits plan after the tax credits. Because many of the uninsured have incomes well below 200 percent of poverty, these income burden estimates after tax credits are conservative.

These findings indicate that if policymakers want to make health insurance affordable to women and older or less-healthy adults, a $1,500 tax credit will not suffice to protect these people from incurring catastrophic out-of-pocket expenses. The alternatives are to set the level of tax credits higher; adjust the level of tax credits according to age, sex, and health; reform the individual market; or combine these alternatives in some manner. Policymakers could consider combining credits with opening up access to group rates through existing private or public group venues, such as the Federal Employees Health Benefit Program, state employee health benefit programs, state-run public insurance plans, or Medicare.

ARE TAX CREDITS ALONE THE SOLUTION TO AFFORDABLE HEALTH INSURANCE?

COMPARING INDIVIDUAL AND GROUP INSURANCE COSTS IN 17 U.S. MARKETS

INTRODUCTION

Long regarded as the "residual insurance market," individual insurance is now at the center of health policy debates about incremental strategies to reduce the number of uninsured Americans. Today, 16 million Americans buy their health coverage in the individual market, accounting for about 9 percent of Americans with private health insurance. About 158 million Americans obtain their health insurance through their employer, constituting the remaining 91 percent of those insured through private insurance markets.[1]

To reduce the number of uninsured Americans, both Democratic and Republican policymakers have sponsored legislation that would allow individuals to receive tax credits for the purchase of health insurance. Most recently, the Bush administration has proposed a $1,000 tax credit for individuals and up to $3,000 for families.[2] Other congressional proposals set the figures at varying levels.

Proponents point to a number of appealing aspects of tax credits. First, both workers and nonworkers can take advantage of tax credits. Second, tax credits do not depend on propping up the employer-based system that has been declining over the past 20 years.[3] Previous public and private initiatives and legislation to encourage firms to offer health insurance have been notable for their lack of success.[4] Third, tax credits are in the spirit of a philosophy that allows the uninsured to choose among many health plans, not just the ones an employer offers. Fourth, individual credits also make the premium cost of coverage transparent and specific to the beneficiary in contrast to either employer group or government-sponsored programs. Individuals choosing higher-cost plans will pay more for such coverage, making them more price sensitive. Many economists believe such exposure could help constrain medical cost inflation.

Critics of a tax credit strategy cite numerous weaknesses in the proposals, but we limit our discussion here to problems arising from reliance on the individual insurance market. First, the cost of administering individual insurance greatly exceeds that for group insurance. Administrative costs constitute 25 to 40 percent of each premium dollar in the individual market, compared with about 10 percent in the group market.[5] As a result, each premium dollar spent in the individual market buys less in terms of benefits than it would in the group market. Second, individual health insurance is vigorously underwritten—

assessing applicants' health and charging people with health problems more than those with no health concerns. As a result, people with serious health problems are unlikely to qualify for coverage or to qualify only at much higher rates than the average for their age group.[6] If they do qualify, the policies may disallow coverage for preexisting medical conditions, except in a handful of states that have barred preexisting condition clauses. Premiums thus reflect the expected medical expenses for each individual, rendering coverage prohibitively expensive for older and sicker persons. Third, even if an individual can pass the medical underwriting screens, individual insurance typically provides less financial protection, and therefore less value, than group insurance. A recent study found, for example, that a typical individual policy covers about 60 percent of medical bills. In contrast, group insurance covers approximately 75 percent of medical costs, even though the covered population in the group market is slightly sicker than that covered by individual insurance.[7]

This paper focuses on a fourth concern about the individual insurance market—the affordability of individual coverage. We compare group and individual insurance costs in 17 markets throughout the country. We also assess the affordability of individual coverage for healthy individuals ages 27 and 55 whose annual income is 200 percent of poverty assuming these individuals would receive a $1,500 tax credit. As of 2002, this threshold income amounts to approximately $18,000 for a single individual and $30,000 for a three-person family. We selected this poverty threshold to reflect the fact that nearly two-thirds of uninsured Americans have incomes at or below this level (Exhibit 1).[8]

METHODOLOGY

We used the Kaiser Family Foundation/Health Research and Educational Trust (KFF/HRET) 2001 Survey of Employer-Sponsored Health Benefits and similar state surveys in California and Iowa for information on employer-based health insurance. We restricted the analysis to those markets in which at least 20 employers participated in the survey. This restriction resulted in the selection of 17 markets for analysis. In each of these markets, we computed the average rate for group coverage based on the employer survey.

Data on individual insurance premiums came from two health insurance websites, E-Health Insurance and Quotesmith, for the 17 selected market areas. To compare group and individual health insurance plans with roughly similar characteristics, we specified plans in the individual market that came as close as possible to benefits typical in the employer group market and plan types prevailing in this market. More people are enrolled in employer-sponsored preferred provider organization (PPO) plans nationally than in any other type of plan. Because PPOs also are widely available in the individual insurance

market, we chose to compare individual and group PPOs. To compare premium rates with roughly similar benefits, the study specified a range of benefits and patient cost-sharing that came as close as possible to the average PPO plan in the employer group market. Using the KFF/HRET 2001 Survey of Employer-Sponsored Health Benefits, we calculated the national average PPO in-network deductible for individuals covered through their employer to be $201, with the most common coinsurance rate at 20 percent (44% of covered workers pay this amount). We therefore set the criteria for individual plans at a $250 in-network deductible and 20 percent coinsurance, and required that the plans cover prescription drugs and mental health (Exhibit 2). We then selected the least-expensive individual PPO plan quoted in each market that met all the specifications and used this plan as our point of comparison. In all 17 markets, the rates quoted were for an applicant before any screening for health problems. As discussed below, however, the individual insurance plans selected were not identical to those offered in the group market. Notably, none of them covered maternity care without a special rider, a benefit offered by almost all employer-sponsored plans.

For further information on the methodology, see the Appendix.

FINDINGS

Young Adults

In general, healthy 27-year-olds, particularly young men, fared well in the individual market relative to group rates. For 27-year-old males, in only one of the 17 markets did the individual plan premium exceed the average premium for employer-sponsored plans (Exhibit 3). This occurred in the Los Angeles–Long Beach market, which had an individual premium of $3,324 for a young male, 21 percent above the group insurance median. In eight markets, the premium was less than $1,800 per year. The annual premium costs for the individual plans across all markets ranged from $1,020 to $3,324 per year for young, healthy males.

Females age 27 did not fare as well as their male counterparts. The median premium of $2,880 was 5 percent higher than the corresponding figure for the group insurance market. In seven of the 17 individual plan markets, premiums exceeded the average group premium in that market. In six markets, rates were substantially above the group rates. Unlike 27-year-old males, who were sometimes quoted rates below $1,200 per year, females did not have any quotes under $1,200. The annual premium costs ranged from $1,284 to $4,788. These rates were always for plans without maternity benefits.

Older Adults

Males and females age 55 always received premium quotes exceeding the average employer-sponsored premium. The median rate quote for a healthy 55-year-old male was $6,120, and for a healthy 55-year-old female it was $6,108. The gender difference seen in the cost of premiums for 27-year-olds was not apparent among 55-year-olds. Both 55-year-old males and females were quoted approximately the same rates within each of the markets, but these still were more than double the group rates in eight of the 17 markets. The median rate quoted for these older adults was more than twice the group market median rate (Exhibit 4).

Geographic Variation

Individual premiums varied widely from one metropolitan area to another, except within the same state, where similar rates prevailed. For both males and females in both age groups among the 17 study markets, rates were highest in the Los Angeles–Long Beach area. Premiums for 55-year-olds were lowest in Cedar Rapids, while for 27-year-olds, Chicago offered the lowest premiums.

Affordability

Although many individual quotes seem modest for younger adults, especially for 27-year-old males, premiums are nonetheless high relative to income. Even for a young male living at 200 percent of the poverty level, these plans would cost, on average, 12 percent of income (not shown in exhibits). Furthermore, our calculations apply to premiums alone and do not include out-of-pocket expenses for deductibles, coinsurance, and uncovered services.

With a tax credit of $1,500, young adults—especially young men—with incomes at the 200 percent of poverty threshold who are otherwise healthy would do relatively well in the individual market. As illustrated in Exhibit 5, in eight of the markets examined, a 27-year-old male would pay nothing or very little (1% or less of income) toward the purchase of health insurance after receiving the tax credit. In three of the markets, however, 27-year-old males would pay at least $1,000 toward premiums after the tax credit. Using the median annual premium across all markets, a 27-year-old male would pay $636 even after a $1,500 tax credit. Females of the same age would spend a greater percentage of income for coverage, as much as 18 percent in one market. Using the median premium across all markets, a 27-year-old female would pay $1,330 for premium costs after a $1,500 tax credit. In the lowest-priced market, a 27-year-old female would pay nothing toward premium costs after a $1,500 tax credit, while in the most expensive market, the same woman would pay $3,288 per year. In nine markets, premium payments

alone would constitute 8 percent or more of annual income for 27-year-old females living at the 200 percent of poverty threshold.

For 55-year-olds, even with a tax credit, premiums would generally be beyond reach on incomes of 200 percent of poverty or less. Even with a tax credit of $1,500 to offset premium costs, on average these individuals still would have to pay one-fourth or more of their income to buy insurance in the majority of markets. There were no instances in which the assumed tax credit reduced the financial burden of individuals below the level often considered catastrophic in this income range—6 percent of income. Even in the least expensive market, individual insurance after a $1,500 tax credit still would consume almost 10 percent of a 55-year-old individual's income.

Comparability

Although selected to be a close match to benefits prevailing in the employer group market, the plans examined in the individual market were more restrictive than those offered by employers. None of the individual plans selected provided coverage for maternity care, although employer-based plans almost always did. As illustrated in Exhibit 6, employer-based plans also were more likely to offer benefits packages with fewer restrictions. Further, they tended to be more generous when it came to spending caps and out-of-pocket expenses.

Coinsurance and Deductibles. Although each of the individual plans in the study had an in-network deductible of $250—very low by individual insurance standards—many of the markets had much lower average employer-sponsored plan deductibles—as low as $20 in one market. Coinsurance rates for individual plans were set at 20 percent for purposes of comparison, but in most of the comparison markets the in-network coinsurance rate for employer-sponsored plans was only 10 percent.

These differences in cost and coverage must be considered when comparing premium costs of individual and employer-sponsored plans. Although some individual plans may have lower premiums for younger enrollees, the coverage tends to be less extensive and the average out-of-pocket costs are greater.

Health. Premium quotes for the individual plans applied to healthy people who did not use tobacco products and had no history of medical problems at the time of application. Although many 27-year-olds may meet these criteria, 55-year-olds often have some history of medical problems or chronic disease (high blood pressure, heart condition, diabetes, etc.) and would expect to pay a good deal more than the premiums quoted for

our healthy 55-year-olds. For example, 64 percent of the uninsured ages 50 to 64 have at least one chronic condition. Among those with employer-based health insurance in this age group, 54 percent have some chronic condition and most have a medical history with evidence of prior illness.[9] In addition, coverage for preexisting conditions is usually excluded by individual plans for new applicants. People with health problems thus might not be able to obtain coverage under individual plans for the services and treatments they need most.

DISCUSSION

Our findings indicate that the individual insurance market can provide affordable health insurance for healthy 27-year-old uninsured males, with the help of a $1,500 tax credit. This is not the case for healthy 55-year-old males and females nor is it the case in more than half the markets studied for young, healthy females.

For older adults, in all 17 markets, premium payments alone for healthy 55-year-olds would constitute a substantial, unaffordable share of income for those living at or below 200 percent of the poverty threshold even after a tax credit of $1,500. Even with a $1,500 tax credit, low-income older or less-healthy adults and women of any age are likely to find insurance beyond their reach based on the rates quoted in the 17 study markets. Once insured, those covered would incur out-of-pocket costs for deductibles, coinsurance, and uncovered expenses. People with incomes below 200 percent of the poverty threshold would spend an even larger share of their income on health insurance.

In contrast, tax credits in the specified range would make health insurance affordable in 13 of the 17 markets for healthy 27-year-old males, using 6 percent of income as the catastrophic threshold. Because healthy 27-year-old males are relatively low users of health care services, the monthly premiums quoted were less than $150 in eight markets. If policymakers want to make health insurance affordable to the healthiest group of the uninsured, who use the system least, flat individual tax credits (not adjusted for age, gender, or health status) will achieve this objective.

These findings indicate that flat rate tax credits alone are insufficient if the policy goal is to make health insurance affordable to low-income adults irrespective of age, gender, health, or location. The alternatives are to set the level of tax credits higher; adjust the level of tax credits according to age, sex, health or geographic location; reform the individual market; or some combination of these approaches. For example, to the extent that market reforms required community rating by age in the individual insurance market, age-adjusted tax credits might provide affordable access to relatively comprehensive

coverage for older Americans. But even doubling the individual tax credit to $3,000 would move only six of the 17 markets into the affordable column for 55-year-old males in the 200 percent of poverty income range. Without reforms, the individual health insurance market, with its medical underwriting, brokerage fees, and high administrative expenses, is unlikely to provide affordable health care for older people even at much higher tax credit rates.

An alternative would be to combine tax credits with new access to insurance through existing public or private group insurance programs. For example, one of the most direct ways to allow access at group rates would be to require all plans providing health insurance to state employees to open up enrollment at group rates to people who want to buy individual insurance. Alternatively, Congress could open up the Federal Employees Health Benefit Plan.[10] With the leverage of state government health plans, states could require insurers to offer guaranteed issuance and renewal and to prohibit medical underwriting. Insurers in turn may require some protection so that uninsured individuals do not select against the plan and purchase health insurance when they are about to incur medical expenses. To guard against such selection concerns, policies could combine a mix of credits, reinsurance, and group options, including access to public programs. Public program options also could include Medicare as a group base to build on for those nearing age 65.[11]

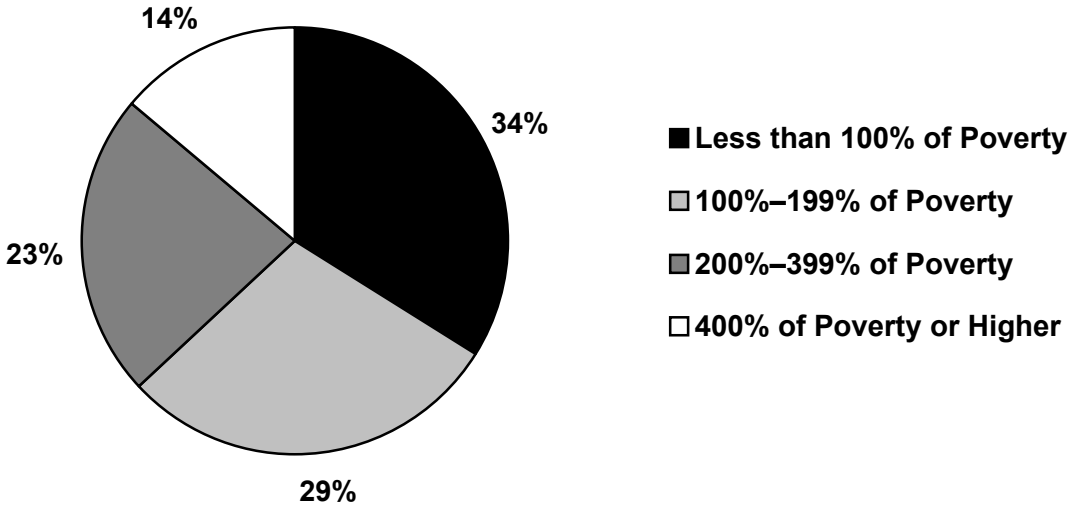
All the above analyses related to premium costs alone. None of our calculations on the affordability of individual policies included out-of-pocket payments for coinsurance, deductibles, and uncovered services. For low-income persons, out-of-pocket expenses can add up to a substantial percentage of income. In a 10-state study of the financial protection afforded by individual insurance, we found that although individual insurance would pay about 63 percent of the medical bills of the population insured through this market, group insurance would pay 75 percent of the medical bills for a similar population.[12] When we add premium costs to probable out-of-pocket expenses, the differences between individual and group insurance become even greater than when premiums alone are considered.

There are certainly many appealing aspects of tax credits despite their limitations. Workers and nonworkers may use them, they offer greater choice of health plans, and they would encourage consumers to be more price sensitive in their purchase of health plans.

Tax credits alone, however, are inadequate. The individual insurance market provides far less protection per premium dollar than the group market. Tax credits would be most useful for people who need health insurance the least—young, healthy males—and would be ineffective in reducing insurance costs to affordable levels for older and

sicker Americans. Tax credits will not make health insurance affordable to individuals at 200 percent or less of the poverty threshold unless they are considerably higher than $1,500. Finally, tax credits cannot reach all people equally irrespective of sex, age, or health status without some reform of the individual insurance market.

Exhibit 1. Distribution of Household Income of Uninsured Individuals, 1999



Source: S. Glied, Columbia University, based on March 2000 Current Population Survey.

Exhibit 2. Individual Health Plan Specifications

Deductible (in-network)	$250
Coinsurance (in-network)	20%
Prescription Drug Benefit	Yes
Inpatient Mental Health Benefit	Yes*
Outpatient Mental Health Benefit	Yes
Maternity Benefit	No
Beneficiary Characteristics	Healthy non-tobacco users only

* Individual plans selected in the state of Iowa did not cover inpatient mental health benefits.

Source: www.ehealthinsurance.com and www.quotesmith.com. Quotes obtained November 2001–January 2002.

Exhibit 3. Comparing Annual Premiums for Single Coverage: Employer-Sponsored PPOs vs. Individual PPOs, by Market Area

Metro Area	Average Group Premium	Individual Insurance Premium for Males Age 55	Individual Insurance Premium for Females Age 55	Individual Insurance Premium for Males Age 27	Individual Insurance Premium for Females Age 27
Providence–Fall River–Warwick, RI/MA	$2,940	**$6,480**	**$6,456**	$2,256	$2,880
Chicago, IL	2,688	**3,336**	**3,384**	1,020	1,284
Detroit, MI	3,168	**4,776**	**4,848**	1,404	1,788
Philadelphia, PA	2,880	**3,720**	**4,560**	1,596	2,040
Pittsburgh, PA	2,352	**4,260**	**4,248**	1,488	1,896
Washington, D.C./ MD/VA/WV	2,808	**7,392**	**7,380**	2,580	**3,300**
Cedar Rapids, IA	2,604	**3,192**	**3,192**	1,104	1,608
Des Moines, IA	2,328	**3,564**	**3,552**	1,248	1,788
Waterloo–Cedar Falls, IA	2,232	**3,204**	**3,192**	1,116	1,776
Los Angeles–Long Beach, CA	2,736	**9,528**	**9,504**	**3,324**	**4,788**
Oakland, CA	2,976	**7,296**	**7,272**	2,544	**3,660**
Orange County, CA	2,700	**7,044**	**7,032**	2,460	**3,540**
San Diego, CA	2,868	**6,120**	**6,108**	2,136	**3,072**
San Francisco, CA	2,832	**7,248**	**7,236**	2,532	**3,648**
Houston, TX	3,444	**6,660**	**6,648**	2,328	3,348
Greensboro, NC*	2,712	**3,900**	**3,888**	1,368	1,716
Rural Area					
Rural Texas	2,436	**6,660**	**6,648**	2,328	**3,348**
Median	**2,736**	**6,120**	**6,108**	**2,136**	**2,880**

* Group insurance data presented for Greensboro were based on averages for the state of North Carolina.

Note: Premiums in boldface indicate rate was higher than the group rate.

Sources:

Average group premium rates from KFF/HRET 2001 Survey of Employer-Sponsored Health Benefits and 2001 HRET California and Iowa state surveys.

Individual insurance rates from www.ehealthinsurance.com and www.quotesmith.com. Quotes obtained November 2001–January 2002.

Exhibit 4. Ratio of Individual to Group Premiums by Market Area

Metro Area	55-Year-Old Males	55-Year-Old Females	27-Year-Old Males	27-Year-Old Females
Providence–Fall River–Warwick, RI/MA	2.20	2.20	0.77	0.98
Chicago, IL	1.24	1.26	0.38	0.48
Detroit, MI	1.51	1.53	0.44	0.56
Philadelphia, PA	1.29	1.58	0.55	0.71
Pittsburgh, PA	1.81	1.80	0.63	0.81
Washington, D.C./ MD/VA/WV	2.63	2.63	0.92	1.17
Cedar Rapids, IA	1.23	1.23	0.43	0.62
Des Moines, IA	1.53	1.53	0.53	0.77
Waterloo–Cedar Falls, IA	1.43	1.43	0.50	0.80
Los Angeles–Long Beach, CA	3.47	3.47	1.21	1.75
Oakland, CA	2.45	2.44	0.85	1.23
Orange County, CA	2.61	2.60	0.91	1.31
San Diego, CA	2.13	2.13	0.74	1.07
San Francisco, CA	2.56	2.55	0.89	1.29
Houston, TX	1.94	1.93	0.68	0.97
Greensboro, NC*	1.44	1.43	0.50	0.63
Rural Area				
Rural Texas	2.74	2.73	0.96	1.38
Median**	**2.24**	**2.23**	**0.78**	**1.05**

* Group insurance data presented for Greensboro were based on averages for the state of North Carolina.

** Median figures are the ratio of individual medians/group medians from Exhibit 3.

Source: Authors' calculation based on Exhibit 3.

Exhibit 5. Insurance Premiums as a Percentage of Income for Individuals Earning at the 200 Percent of Poverty Threshold and Receiving a $1,500 Tax Credit

Metro Area	55-Year-Old Males	55-Year-Old Females	27-Year-Old Males	27-Year-Old Females
Providence–Fall River–Warwick, RI/MA	28%	28%	4%	8%
Chicago, IL	10	11	–3	–1
Detroit, MI	18	19	–1	2
Philadelphia, PA	12	17	1	3
Pittsburgh, PA	15	15	0	2
Washington, D.C./ MD/VA/WV	33	33	6	10
Cedar Rapids, IA	9	9	–2	1
Des Moines, IA	12	11	–1	2
Waterloo–Cedar Falls, IA	10	9	–2	2
Los Angeles–Long Beach, CA	45	45	10	18
Oakland, CA	32	32	6	12
Orange County, CA	31	31	5	11
San Diego, CA	26	26	4	9
San Francisco, CA	32	32	6	12
Houston, TX	29	29	5	10
Greensboro, NC	13	13	–1	1
Rural Area				
Rural Texas	29	29	5	10
Median	**26**	**26**	**4**	**8**

Source: Authors' calculation based on rates in Exhibit 3 minus a $1,500 tax credit related to 200 percent of poverty threshold for one person.

Exhibit 6. Characteristics of Employer-Based Plans

Metro Area	Average Deductible (in-network)	Most Common Coinsurance (in-network)	Prescription Benefits Covered	Outpatient Mental Health Benefits Covered	Inpatient Mental Health Benefits Covered
Providence–Fall River–Warwick, RI/MA	$ 20	N/A	97%	100%	95%
Chicago, IL	157	10%	100	99	99
Detroit, MI	84	10	88	100	100
Philadelphia, PA	83	10	81	100	97
Pittsburgh, PA	106	20	100	100	100
Washington, D.C./ MD/VA/WV	48	10	100	100	100
Cedar Rapids, IA	302	10	97	100	100
Des Moines, IA	254	10	99	100	100
Waterloo–Cedar Falls, IA	215	10	100	99	99
Los Angeles–Long Beach, CA	126	10	100	100	100
Oakland, CA	243	10	96	85	85
Orange County, CA	173	20	100	100	100
San Diego, CA	101	10	100	96	96
San Francisco, CA	204	10	100	93	86
Houston, TX	257	20	100	100	100
Greensboro, NC*	222	0	89	89	89
Rural Area					
Rural Texas	249	20	100	98	99
Median	**173**	**10**	**100**	**100**	**99**
Selected Individual Plans	**250**	**20**	**100**	**100**	**82**

* Group insurance data presented for Greensboro were based on averages for the state of North Carolina.

Source: KFF/HRET 2001 Survey of Employer-Sponsored Health Benefits and 2001 HRET California and Iowa state surveys.

APPENDIX. DETAILED METHODOLOGY

Group Health Insurance Data

Using the 2001 Kaiser Family Foundation/Health Research and Educational Trust (KFF/HRET) 2001 Survey of Employer-Sponsored Health Benefits, we identified eight metropolitan statistical areas (MSAs) with at least 20 employers in the sample. We also selected one rural market in Texas, the state that had the greatest representation of rural respondents in the employer-sponsored health benefits survey. All rural Texas respondents were grouped together to form this observation.

We used the 2001 California and Iowa surveys of Employer Health Benefits published by HRET to identify an additional seven MSAs with at least 20 survey respondents. Four MSAs were located in California: Oakland, Orange County, San Diego, and San Francisco. Iowa was the site of three more MSAs: Cedar Rapids, Des Moines, and Waterloo–Cedar Falls.

Because no MSAs from the southeastern United States were among the 16 local areas, we selected one from the KFF/HRET 2001 Survey of Employer-Sponsored Health Benefits—Greensboro, North Carolina.[13] We included all survey respondents in the state of North Carolina in calculating employer-based insurance figures because there were not sufficient numbers in any one market.[14] For each market area, we calculated the average employer-sponsored insurance premiums for each of the markets.

The KFF/HRET survey is an annual survey of employer-based health benefit plans, now in its third year under the sponsorship of KFF/HRET.[15] National Research LLC, a Washington, D.C.-based survey firm, conducted telephone interviews with employee benefits managers from January to May 2001. The survey questionnaire asked a series of questions about the employer's largest indemnity insurer, health maintenance organization (HMO), preferred provider organization (PPO), and point-of-service (POS) plan. National Research completed interviews with 1,907 public and private employers ranging in size from three employees to hundreds of thousands of workers.

The survey sample, stratified by firm size (number of workers) and industry, was drawn from a list of the nation's employers compiled by Dun & Bradstreet. The overall response rate was 50 percent.

The California and Iowa Surveys of Employer Health Benefits are conducted in the same manner as the KFF/HRET 2001 Survey of Employer-Sponsored Health Benefits. The California Survey of Employer Health Benefits included 846 employers ranging in size from three employees to thousands of workers. The Iowa Survey of Employer Health Benefits included 386 employers with from 100 to thousands of workers.

Because the firms in each of the survey samples were chosen randomly, it was possible to use statistical weights to extrapolate the results to national, firm size, regional, and industry figures. We calculated weights by determining the basic weights, applying a nonresponse adjustment, and then applying a poststratification adjustment. All data presented here were weighted using the PPO plan weight, which represented the number of workers enrolled in PPO plans.

Individual Health Insurance Data

Using the 16 MSAs and one rural area chosen, we randomly selected one zip code in each area. We then used the websites www.ehealthinsurance.com and www.quotesmith.com to collect data on insurance premiums for individual PPO plans in each of the markets.[16] To select PPO plans from the individual market, we chose plans according to deductibles, coinsurance, and covered benefits. We limited individual PPO plans to those with a $250 in-network deductible and 20 percent coinsurance to approximate the design of employer-sponsored group health plans. All individual insurance plans also had to offer some coverage for prescription drugs and outpatient and inpatient mental health coverage (with the exception of the Iowa plans). We used these criteria to match the individual insurance plans as closely as possible to the average employer-sponsored group insurance plan, but the comparison is nevertheless a best-case analysis representing the upper limits of value for individual plans.

For each of the 17 zip codes, we collected data on monthly premiums for an individual plan for a 27-year-old male, a 27-year-old female, a 55-year-old male, and a 55-year-old female. For our purposes, all individuals were described as non-tobacco users, and their medical histories were not factored into the premium cost; the price quotes, therefore, were limited to healthy individuals. For each individual, we identified plans in each market that met our criteria. From those plans, we selected the one with the lowest monthly premium. As a result, we could display insurance premium rates for the four representative categories across the selected 17 markets.

Analysis

Affordability. We calculated the cost of individual insurance in each market as a percentage of income at 200 percent ($17,918) of the 2000 poverty threshold as determined by the U.S. Census Bureau. Our analysis assumed a tax credit of $1,500 toward buying health insurance. We calculated the annual cost of each plan, deducted the $1,500 tax credit, and divided the result by annual income. These calculations did not include estimated out-of-pocket expenses for deductibles, coinsurance, copayments, and uncovered services.

NOTES

[1] P. Fronstin, "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2001 Current Population Survey," EBRI Issue Brief no. 240 (Washington, D.C.: Employee Benefit Research Institute, December 2001).

[2] "President's budget expands access to health care: New health credits, more health centers, state purchasing pools would assist uninsured," U.S. Department of Health and Human Services, Press Release, January 30, 2002, http://www.hhs.gov/news/press/2002pres/20020130.html.

[3] T. Gilmer and R. Kronick, "Calm Before the Storm: Expected Increase in the Number of Uninsured Americans," *Health Affairs* 20 (November/December 2001): 207–210; J. Gabel, "Job-Based Health Insurance, 1977–1998: The Accidental System Under Scrutiny," *Health Affairs* 18 (November/December 1999): 62–74.

[4] W. D. Helms, A. K. Gauthier, and D. M. Campion, "Mending the Flaws in the Small-Group Market," *Health Affairs* 11 (Summer 1992): 7–27; S. Glied, *Challenges and Options for Increasing the Number of Americans with Health Insurance* (New York: The Commonwealth Fund, January 2001).

[5] M. A. Hall, "The Geography of Health Insurance Regulation," *Health Affairs* 19 (March/April 2000): 173–184.

[6] K. Pollitz, R. Sorian, and K. Thomas, *How Accessible Is Individual Health Insurance for Consumers in Less-Than-Perfect Health?* (Menlo Park, Calif.: Henry J. Kaiser Family Foundation, 2001).

[7] J. Gabel, K. Dhont, H. Whitmore, and J. Pickreign, "Individual Insurance: How Much Financial Protection Does It Provide?" *Health Affairs* web exclusive (April 17, 2002), available at www.healthaffairs.org.

[8] "Special Conference Issue: Strategies to Expand Health Insurance for Working Americans," *Inquiry* 38 (Summer 2001).

[9] E. Simantov, C. Schoen, and S. Bruegman, "Market Failure? Individual Insurance Markets for Older Americans," *Health Affairs* 20 (July/August 2001): 139–149.

[10] For a recent discussion of this approach, see S. Glied, "Challenges and Options for Increasing the Number of Americans with Health Insurance," and B. Fuchs, "Increasing Health Insurance Coverage through an Extended Federal Employees Health Benefits Program," *Inquiry* 38 (Summer 2001): 177–192.

[11] See *Inquiry* 38 (Summer 2001) for a discussion and analysis of various options that combine mixed approaches.

[12] J. Gabel et al., "Individual Insurance."

[13] Greensboro, North Carolina, was chosen because there were more firms from North Carolina in the national sample of employers than in other southeastern states, and more firms from Greensboro than from other metropolitan areas in the state.

[14] The MSAs are not representative of all regions of the United States. Although every effort was made to include localities from each region, we were limited by the availability of individual PPO plans that met our selection criteria and by the availability of employer-based insurance data from the KFF/HRET survey within each MSA.

[15] From 1987 to 1991, the Health Insurance Association of America (HIAA) conducted the survey using a similar questionnaire. KPMG Peat Marwick conducted the survey from 1991–1998.

[16] All individual premium quotes were collected in November 2001 except those for Greensboro, which were collected in January 2002.

RELATED PUBLICATIONS

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#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.

#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.

#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.

#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.

#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.

#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.

#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.

#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.

#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 policy makers to trade off access for the highest-risk groups against keeping access for the lowest risk-groups. This paper, part of the series Strategies to Expand Health Insurance for Working Americans, discusses how individual insurance markets might best be designed in view of this trade-off. 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.

#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.

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.

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.

#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.

#358 *Job-Based Health Insurance, 1977–1998: The Accidental System Under Scrutiny* (November/ December 1999). Jon R. Gabel. *Health Affairs,* vol. 18, no 6. In this article, the author describes how the U.S. employer-based health insurance system evolved following World War II and shows that the proportion of workers insured through their jobs has fallen steadily in the past two decades—a decline most prominent among disadvantaged groups.

#251 *The Financial Burden of Self-Paid Health Insurance on the Poor and Near-Poor* (April 1998). Jon Gabel, Kelly Hunt, and Jean Kim, KPMG Peat Marwick, LLP. Through analysis of KPMG's 1996 *Health Benefits Survey* of 1,965 small and large employers, explore the cost of health insurance for low income families, and estimate the amount of government subsidies needed to make it affordable to them. Gabel's calculations show that if the government were to subsidize the purchase of insurance so that families paid no more than five percent of their income for coverage, the average annual subsidy for a poor individual would be $2,119, and for a poor family, $5,425.