

Covering America

REAL REMEDIES
FOR THE UNINSURED

Economic and Social Research Institute

CURRENT POLICY SERIES

Number 4 — October 2002

Nine Billion Dollars a Year to Cover the Uninsured: Possible Common Ground for Significant, Incremental Progress

*by Stan Dorn and Jack A. Meyer**

Summary

Earlier this year, leaders in both parties proposed investing significant resources to cover uninsured Americans. Budgets from both the Administration and the Senate Budget Committee allotted approximately \$9 billion a year over the next 10 years to expand health coverage. At the national level, such bipartisan commitment to investing significant sums addressing domestic priorities is extraordinary and rare. However, largely because of philosophical disagreements about whether to cover the uninsured by creating tax credits or expanding public programs, proposals to implement these budget commitments did not move forward.

Even while considering proposals to help smaller, discrete groups of uninsured Americans, policymakers have had trouble reaching agreement. For example, when federal stimulus legislation proposed investing more than \$19 billion over two years to cover workers losing their jobs during the current economic downturn, policymakers could not resolve disputes about how to provide insurance. As a result, health coverage for unemployed workers was stripped out of the bill before it became law.

In contrast, the more recent debate over trade policy resulted in bipartisan agreement to provide health coverage to more than 100,000 workers displaced by foreign competition and selected retirees. In the nation's first incremental coverage expansion since adoption of the State Children's Health Insurance Program (SCHIP) in 1997, these individuals will receive health insurance tax credits that can be used to purchase insurance from certain employers, state-level health insurance pools, and (in limited cases) the nongroup market.

As with SCHIP and now trade, bridge-building across philosophical divides is likely to remain essential for future coverage expansions to have reasonable prospects of enactment. This paper suggests that, given the roughly \$9 billion a year that leaders in both parties agree should be invested to cover the uninsured, a variety of approaches could build on these earlier, bipartisan accomplishments and cover a large group of uninsured. We explore such approaches in the following three categories:

- **Individual choice strategies.** Policies in this category give uninsured families a range of options for using

* The following people made special contributions to this paper by suggesting many key ideas and greatly helping to shape the analysis—Stuart M. Butler, The Heritage Foundation; Lynn Etheredge, Health Insurance Reform Project of George Washington University; and Alan Weil, the Urban Institute. However, only the coauthors are responsible for the paper in its final form.

health insurance subsidies. One example of such a policy would use refundable and advanceable federal income tax credits to give low-income, uninsured individuals a choice among group plans in a health insurance marketplace modeled after the Federal Employees Health Benefits Program (FEHBP). The basic features of FEHBP would apply, using flexible federal guidelines and market pressures to encourage low-cost, innovative, high-quality care that meets consumers' needs. Some aspects of FEHBP, however, would change. National policy adjustments would encourage plan participation and make coverage affordable for uninsured workers, most of whom earn much lower incomes than do average federal employees.

- **Hybrid strategies.** These strategies couple public program expansions favored by some policymakers with tax credits favored by others. Under one possible hybrid approach, state Medicaid programs could receive the flexibility to cover all uninsured residents with incomes below a state-selected level, regardless of household category. This would overcome two current limits on state flexibility: states now must use different eligibility rules for different populations, based on such factors as age, parenthood, and disability; and states without federal waivers are forbidden from covering non-elderly, non-disabled adults without dependent children, no matter how poor they are. Policymakers could encourage implementation of this new option by raising federal matching percentages above standard Medicaid levels.

At the same time, refundable, advanceable federal income tax credits would pay for health insurance purchased by low- and moderate-income employees of small businesses. Such credits could be used in any market available to workers under current law, including the nongroup market. In states where credit recipients lack access to comprehensive, group coverage with

benefits and premium costs resembling the most popular insurance provided to federal employees, the federal government would contract with "fallback plans" to offer such coverage.

- **State-based strategies.** This group of strategies gives states resources to choose from a menu of policy alternatives for expanding coverage. States could use such resources to expand public programs; to provide health insurance tax credits using state income tax systems; to provide health insurance vouchers (the functional equivalent of tax credits) in states without income taxes; to implement market reforms like purchasing cooperatives and high-risk pools; to provide financial incentives for employers to expand coverage; to permit uninsured families to enroll in state-purchased coverage, with costs based on ability to pay; or to use other strategies designed by states or localities. Federal policymakers contemplating this approach need to consider carefully the requirements that states would be asked to meet in spending these funds (including whether any matching funding would be required) and the methods that would hold states accountable.

Working through all the details of these approaches will not be easy. And other bipartisan policies are certainly possible. For example, policymakers could extend to other uninsured Americans the basic approach taken in recent Trade Adjustment Assistance (TAA) legislation, which provides health insurance tax credits that are primarily usable through state-based insurance pools.

This paper's goal is not to advocate any particular policy. Rather, its purpose is to illustrate, through specific examples, that differing policy preferences and political philosophies can be bridged through well-designed, pragmatic proposals to help significant numbers of uninsured Americans, using resources already promised by leaders in both parties.

Contents

INTRODUCTION	4
CATEGORY ONE: INDIVIDUAL CHOICE STRATEGIES, EXEMPLIFIED IN A MARKET MODELED AFTER FEHBP	5
Elements of FEHBP that could apply to the uninsured	5
Revisions to FEHBP needed to serve the uninsured	5
Tax credit design	6
CATEGORY TWO: HYBRID STRATEGIES	11
Public program expansion	11
How can states be encouraged to implement this option?	13
Tax credits to buy private insurance	13
Limited vs. comprehensive benefits: what's the right policy goal?	15
The interface between public programs and tax credits	16
CATEGORY THREE: STATE-BASED STRATEGIES	17
Menu of state options	17
Standards for approving state plans	17
Trade-offs in federal legislative design	18
Accountability strategies	19
MAKING NEW DOLLARS GO FARTHER	20
CONCLUSION	21

Introduction

Earlier this year, policymakers from both parties expressed their willingness to spend significant sums to cover the uninsured. President Bush's 2003 budget proposal, for example, devoted \$89 billion over 10 years to a health insurance tax credit,¹ along with other measures to enhance access to health care. For that same period, the Senate Budget Committee's 2003 Budget Resolution allocated up to \$95 billion to cover the uninsured by expanding public programs like Medicaid and the State Children's Health Insurance Program (SCHIP).²

Despite this agreement on resources, policymakers have been unable to resolve their disagreements about methods to help the uninsured. Legislators have not only failed to address the overall problem of uninsurance, they have a mixed record helping smaller groups of uninsured. During last winter's economic stimulus debate, for example, policymakers proposed spending up to \$19 billion over two years to provide health coverage to uninsured workers laid-off during the current economic downturn. Health coverage was removed from the final stimulus bill, however, because Congress could not agree on a specific approach to covering these workers.

These disagreements reflect, in part, broader philosophical divides between advocates of tax credits and supporters of public programs like Medicaid and SCHIP. If such philosophical differences persist in future years, significant progress toward covering most uninsured Americans will require policies that are acceptable to policymakers with a variety of philosophies and policy goals.

Federal policymakers recently took a small but important step in this direction by approving Trade Adjustment Assistance (TAA) legislation providing refundable, advanceable health insurance tax credits to more than 100,000 displaced workers and retirees.³ Such credits can be used to purchase insurance through state-based groups, certain employers, and, in limited cases, the nongroup market.⁴

To build on both that recent accomplishment and this year's unusual bipartisan commitment to significant resources expanding health coverage, this paper suggests that, using the roughly \$9 billion in annual funding already approved by leaders of both parties, policies that further bridge this philosophical gap could make significant progress in covering uninsured Americans. We explore such policies in three categories:

- **Individual choice strategies** give uninsured families a range of options for using health insurance subsidies. The example discussed below uses the Federal Employees Health Benefits Program as a model. It provides tax credits to help individuals select the group coverage option that best meets their individual needs, using market incentives to encourage (but not force) selection of lower-cost plans.

- **Hybrid strategies** couple public program expansions with tax credits. The particular hybrid discussed below combines a Medicaid expansion to serve the poorest uninsured with a refundable tax credit covering low- and moderate-income, uninsured Americans working for small employers.

- **State-based strategies** give states resources to choose from a menu of policy alternatives favored by different federal policymakers, coupled with minimum standards, safeguards, and accountability measures to ensure that federal funds achieve their purpose.

Such approaches accept each side of the philosophical divide as sincere, legitimate, and unlikely to be persuaded to switch sides. These strategies address such differences either by granting each side "half a loaf" or by assigning certain decisions to states or individuals, rather than federal policymakers. Put simply, the policies described in this paper try to achieve progress without asking either major school of thought to violate fundamental principles.

This paper addresses each of these three policy categories in turn. Within each category, we either identify key questions facing federal policymakers or present concrete examples of policies that could effectively cover large numbers of uninsured Americans using approaches with potential bipartisan appeal.

Other bipartisan approaches are certainly possible. For example, policymakers could extend to other uninsured populations the TAA statutory approach⁵ of providing tax credits for coverage primarily usable through state-based insurance pools.

To be sure, incremental strategies have limitations, beyond helping only some of the uninsured. Frequently, incremental steps add new overlays that make the already fragmented health care system even more complex. That said, bipartisan agreement may be easier to secure on an incremental than a comprehensive approach. Nine billion dollars a year will reach only some of the uninsured. Accordingly, policymakers developing an incremental proposal can single out the populations and approaches that have the greatest chance to expand coverage significantly without provoking unyielding partisan or ideological resistance.

Our goal is not to advocate any particular policy. Rather, we hope to illustrate, through specific examples developed in some detail, that differing policy preferences and political philosophies can be bridged through well-designed, pragmatic proposals to help significant numbers of uninsured Americans.

Note: changes like those described below involve numerous technical questions that are relevant to detailed policy design but are not central to understanding the main issues. To make this paper more accessible to readers interested in the forest rather than the trees, we discuss these important details in footnotes, instead of the text.

Category One: Individual Choice Strategies, Exemplified in a Market Modeled after FEHBP

Of course, many different individual choice approaches are possible. The approach described in this section provides refundable, advanceable tax credits that uninsured people can use to choose from a variety of health plans, using the Federal Employee Health Benefits Program (FEHBP) as a model. Similar approaches have received some support from across the philosophical spectrum, ranging from Senator Bill Bradley's Presidential campaign⁶ to analysts at The Heritage Foundation,⁷ suggesting that this may be a promising bipartisan option.

Elements of FEHBP that could apply to the uninsured

Throughout the country, FEHBP⁸ offers federal employees, retirees, and certain others (for example, divorced former spouses of federal workers, certain employees of the District of Columbia, etc.) fairly comprehensive coverage provided by literally hundreds of health plans. FEHBP beneficiaries may choose between nationwide, fee-for-service plans, local HMOs, some point-of-service (POS) options, and one newly added plan offering "consumer-driven health care."⁹ Between 12 and 20 plans are available to each beneficiary, depending on their area of residence. Covered services, cost-sharing, premium amounts, financial, quality, and administrative requirements are set by the Office of Personnel Management (OPM) through periodically revised national standards and negotiations with individual plans, undergirded by limited regulatory¹⁰ and statutory¹¹ requirements. Participating plans may not reject any FEHBP beneficiary, impose preexisting condition limits, or charge different premiums for any reason other than coverage category (worker-only vs. family coverage, etc.). Beneficiaries may change plans during an annual "open season."

The federal government pays 75 percent of total premium costs, up to a maximum amount equal to 72 percent of the weighted average premium cost for all FEHBP plans, as determined annually by OPM. The employee pays premium costs not covered by the federal government, using pre-tax dollars that the employing agency automatically withholds from each paycheck (unless the employee affirmatively opts out of such withholding). Before open season, OPM makes available to beneficiaries clear information about each plan describing benefits, cost, provider networks, and performance on certain quality indicators.¹²

These elements can be translated into an "FEHBP look-alike" program. Serving uninsured people who qualify (as described below) for refundable, advanceable health insurance tax credits, such a program includes the following elements:

- A federal agency, perhaps within the Department of Labor, offers tax credit beneficiaries coverage through contracted, group health plans, including indemnity plans, HMOs, PPOs, and POS plans.¹³ The agency informs consumers about health plan options, modeling educational materials after OPM information for federal employees. As with FEHBP, a program manager, rather than a regulatory agency, handles administration.

- Such plans offer a variety of benefits packages and cost-sharing options, which can change over time, consistent with minimum statutory and regulatory standards. Such standards require, among other things, that each participating plan's actuarial value cannot fall below some percentage of actuarial value for the most popular FEHBP plan among federal employees during the previous year.

- Any HMO, PPO, indemnity, or POS plan participating in FEHBP, Medicaid,¹⁴ SCHIP, and perhaps other programs (such as state employee insurance) is automatically deemed eligible, without any actuarial analysis, to participate in this FEHBP-look-alike program.

- With tax credit beneficiaries, plans can neither deny enrollment nor impose preexisting condition limits. Premiums are not risk-rated; that is, plans charge all such beneficiaries the same premiums within each coverage category (worker-only, family, etc.).

- Tax credit amounts rise proportionately as premium costs increase, up to a capped premium level.¹⁵ Beneficiaries choosing a more expensive plan pay the amount above the cap. These features give plans incentives to attract business by keeping premiums low, while still preserving, for the generally low-income population qualifying for credits, affordable coverage and meaningful consumer choices up to the capped premium level.¹⁶

- As with FEHBP, prompt enrollment must take place within a defined time frame, such as a certain number of days after receiving notice of potential eligibility for health coverage.¹⁷ Otherwise, beneficiaries could delay seeking assistance until they know they need care, driving up average costs and premiums.

- As with employing federal agencies under FEHBP, family premium payments are withheld from the worker's paycheck. Collection of premium payments and enrollment mechanisms, consistent with the FEHBP model, are discussed in more detail below.

Revisions to FEHBP needed to serve the uninsured

For an FEHBP-like strategy to serve low-income, uninsured Americans effectively, some changes are needed:

- Limits on co-payments, coinsurance, and deductibles are important to assuring that low-income enrollees obtain good access to health care.

- Many health plans may hesitate to join such a program, which will have smaller enrollment than FEHBP and serve a new group of beneficiaries with whom plans lack claims experience. To encourage plan participation, profit margins for health plans may need to increase above the FEHBP allowance of 1.1 percent. In addition, particularly during the program's first few years, before claims experience accumulates, the federal agency administering the program may need to provide reinsurance or stop-loss protection.¹⁸

In addition, it is not clear that any point would be served by extending to this new program the current FEHBP prohibition against additional indemnity plans joining the program.

Tax credit design

A basic design question is whether to provide smaller tax credits for numerous uninsured people or larger credits for comparatively few. Analysts disagree about the precise subsidy size needed for significant take-up by the low-income uninsured.¹⁹ Given this uncertainty and the limited impact of even \$9 billion a year, the policies described below tilt towards large credits, controlling costs through careful targeting of the beneficiary group and the incentives for selecting lower-priced coverage described above. One such approach to health insurance tax credits has the following elements:

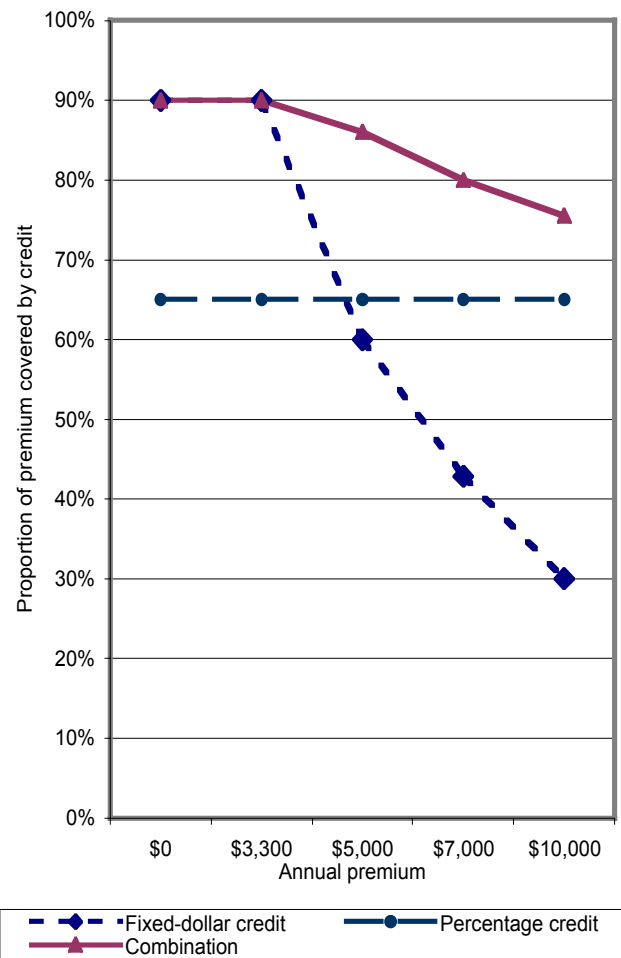
- **Credit eligibility.** Credits go to two groups: (1) low-income Americans with incomes below a specified percentage of the federal poverty level (FPL), such as 100 percent of FPL;²⁰ and if resources permit (2) workers who have all the following characteristics:²¹ (a) their income is above the maximum level for low-income coverage but below a somewhat higher threshold (for example, 250 percent of FPL); (b) they are employed by a small firm (such as a company with fewer than 10 employees); and (c) they either lack access to employer coverage or can buy such coverage only by spending above a certain proportion (for example, 5 percent) of household income.²² The relatively few with access to employer-sponsored insurance who qualify for credits can use scaled-back credits to purchase employer coverage, outside the FEHBP look-alike system.²³ Excluded from both groups of credit beneficiaries are individuals eligible for Medicaid or SCHIP²⁴ and households failing to apply for tax credits within a certain period of first receiving notice that they may qualify. Dependents are also eligible for credits.

- **Credit amount.** Tax credits cover a fixed dollar amount of health insurance premiums (for example, \$1,000 per adult and \$500 per child, with a maximum of \$3,000 per family), plus a certain proportion (for example, 65 percent) of premium costs above that fixed level. The credit is capped at 90 percent of premiums. This structure combines elements of the Bush Administration's tax credit proposal (fixed dollar amounts and a 90 percent cap) with

elements of the 65 percent TAA health insurance tax credit.

Under this combined structure,²⁵ credits cover the highest proportion of costs for plans with the lowest premiums. As plans grow more expensive, credits cover an ever-decreasing fraction of premiums. This contrasts with proportional credits, which cover the same percentage, regardless of premium amounts. As Figure 1 shows, the suggested approach also contrasts with fixed-dollar credits; the percentage of costs covered as premiums rise does not drop as sharply with combined credits as with fixed-dollar credits. This combined structure seeks to assure low-income households affordable choices of coverage beyond the least expensive plans while still giving all enrollees meaningful financial incentives to purchase less expensive coverage.

Figure 1: Impact of credit structure on maximum subsidy levels for various premiums



Notes: (1) Fixed dollar credit covers the higher of 90% of premiums or \$3,000. (2) Percentage credit covers 65% of premiums. (3) Combination credit covers \$3,000 plus 65% of remaining premium costs, capped at 90% of premiums. (4) Table shows maximum premium amounts, without any reductions based on income. Calculations by ESRI, August 2002.

Table 1, below, illustrates the impact of various credits on a family's cost to purchase a \$7,000 annual health insurance policy, which is 12 percent below the current national average for employer coverage.²⁶ For such a health plan, the worker's costs drop from \$4,000 with a \$3,000 fixed credit, to \$2,450 for a 65 percent proportional credit, to \$1,400 a year for the combination of fixed and proportional credits described above. This difference could have a substantial impact on take-up rates among lower-income families.²⁷

Table 1: Impact of various credits on annual family costs for a \$7,000 health insurance policy

TYPE OF CREDIT	AMOUNT OF CREDIT	ANNUAL FAMILY PREMIUM SHARE
Fixed	\$3,000	\$4,000
Proportional	\$4,550	\$2,450
Combination	\$5,600	\$1,400

See notes for Fig. 1.

- **Additional effect of household income.** Tax credits are fully refundable (that is, families owing little or no income tax still receive the full credit). To target federal resources to households with the greatest need for help, credits drop in value as household income rises. The most commonly suggested approach to such a phase-out simply lowers credit amounts to zero or another minimum level (for example, 40 percent of maximum credit amounts)²⁸ on a "straight line" basis as income rises to maximum eligibility levels.²⁹

The approach described here achieves similar results using a different, offset-based method. With an offset-based phase-out, credit size is fixed, regardless of income. For income tax purposes, Adjusted Gross Income (AGI) increases by an amount determined simply by the credit size, regardless of household income. Because the income tax uses progressive tax brackets, tax liabilities automatically grow as household income rises, offsetting credits by increasing amounts.³⁰ Suppose, for example, that AGI increases by the amount of the credit.³¹ For a household in the 15 percent tax bracket, federal income tax liability grows by an amount equal to 15 percent of the credit, resulting in a net subsidy equal to 85 percent of the maximum credit amount; in the 27.5 percent bracket, tax liability increases by 27.5 percent of the credit amount, resulting in a 72.5 percent net subsidy; etc.^{32 33}

- **Advance payment.** At the beneficiary's request, the Treasury Department advances the credit through periodic payments to the beneficiary's health plan. Advance payments deliver subsidies when insurance premiums are due. They are needed for tax credits to effectively serve low-income workers, who typically cannot "front" monthly premium payments based on the expectation of year-end tax credits. This approach borrows several fea-

tures of TAA health insurance tax credits: for workers to use advance payments, state or local agencies must issue them eligibility certificates, which are then forwarded to health plans; advance payments reduce the taxpayer's final entitlement to the credit, as calculated when filing a year-end income tax return; but that year-end credit amount cannot be reduced below zero, so taxpayers are not required to repay the government if advance payments turn out to be too high.³⁴ Such a limit on tax reconciliation may be needed for low-income workers to use advance payment. Very few such workers take advance payment of Earned Income Tax Credits (EITC), apparently because EITC advance payments that turn out to be excessive can endanger year-end tax refunds or create net tax liabilities.³⁵

- **Enrollment.** Even among those with incomes below 100 percent of FPL, 63.2 percent of uninsured adults worked during 2001.³⁶ Accordingly, both these beneficiaries and the moderate-income group can enroll at work (and in other venues as well, to reach non-workers),³⁷ using automatic payroll withholding to pay the worker's share of the premium. The employer forwards a single payment of all such withholding for a given period to a private service center. Such centers also collect premium payments from beneficiaries for whom automatic withholding is not in effect, consolidate premium payments from all sources, and forward them to the appropriate health plans. Relieving health plans of the need to collect premiums could help plan recruitment substantially, and centralizing these collection and payment responsibilities may lower administrative costs. These centers could be either firms that today handle similar functions for small companies or new entities contracting with the federal government. Finally, default enrollment procedures require newly hired, eligible workers affirmatively to opt out if they do not wish to receive credits.³⁸

- **Reports.** Some entity (perhaps the General Accounting Office) is asked (and funded) to provide Congress with periodic reports analyzing the implementation of the credit and making recommendations for policy improvements.

As with almost any health insurance subsidy proposal, this approach makes various choices to live within a budget. These choices juggle policy design features, acknowledging that costs increase when eligibility broadens, enrollment widens, or subsidy amounts increase. Tables 2 and 3 show how various design features affect cost and indicates roughly where the approach suggested here fits on applicable spectra.

As these tables show, the approach discussed here focuses resources in three principal areas: a large subsidy amount, maximizing enrollment among those eligible for credits, and attempting to provide access to comprehensive coverage. Costs are controlled primarily by limiting eligibility tightly, reducing credit amounts as income rises, and us-

Table 2: Program costs and design elements affecting eligibility and enrollment: How this tax credit approach compares to other possible options

POLICY ELEMENT		LOWEST COST OPTION	HIGHEST COST OPTION
ELIGIBILITY	<i>Income</i>	Only low-income people qualify for credits	People of any income level qualify for credits
	<i>Access to employer coverage</i>	Credits denied to people with any access to ESI	ESI is irrelevant to eligibility for credits
	<i>Other eligibility requirements</i>	Significant additional requirements	No additional requirements
ENROLLMENT	<i>Default procedures</i>	Affirmative application required to obtain credits	Automatic enrollment, unless individuals opt out
	<i>Tax consequences for advance payments</i>	Full reconciliation if advance payments erred	No possible tax consequences

Note: **X** indicates where the approach described in this section fits on each continuum of policy options.

Table 3: Program costs and design elements affecting subsidy level and coverage: How this tax credit approach compares to other possible options

POLICY ELEMENT		LOWEST COST OPTION	HIGHEST COST OPTION
SUBSIDY LEVEL	<i>Basic subsidy amount</i>	Low	High
	<i>Effect of higher income</i>	Subsidy drops	No effect
COVERAGE THAT SUBSIDIES CAN BUY	<i>Comprehensive plans</i>	Cannot use credits to buy such plans	Such plans are the only option for using credits
	<i>Limited benefit plans</i>	Such plans are the only option for using credits	Cannot use credits to buy such plans
	<i>Other measures to limit costs of coverage</i>	Significant measures	No measures

Note: **X** indicates where the approach described in this section fits on each continuum of policy options.

ing market mechanisms to limit costs by asking enrollees who select more expensive coverage to pay higher premium amounts. Other trade-offs among these parameters are, of course, possible as well.

One important question is whether these credits are large enough to make coverage affordable for low-income, uninsured people. As Table 5 shows, credits are sufficiently large that beneficiaries would be responsible for roughly 21 percent to 25 percent of premiums for typical FEHBP coverage. This represents more affordable premium costs than under many other tax credit proposals. Under this approach, workers with income at 200 percent of FPL, for example, could purchase such coverage by spending approximately 4 percent to 5 percent of household income. (Similar results would follow from an alternative, simpler credit design more closely based on FEHBP that would pay 75 percent of premiums up to a capped level.) Table 4 shows that enrollees

in typical employer insurance now pay comparable amounts for family coverage and somewhat less for worker-only insurance.

The lowest-income workers, however, may have serious problems purchasing FEHBP-type coverage, even with this comparatively generous subsidy. Some research suggests that few low-income households use public subsidies if family premiums exceed even 1 to 3 percent of household income.³⁹ As Table 5 shows, the credits discussed here would require households with earnings at 100 percent of FPL to spend roughly 8 percent to 10 percent of all income to purchase FEHBP coverage with premiums between the 35th and 65th percentiles of all FEHBP plans nationwide. Policymakers wishing to ensure that such comprehensive plans are affordable for the lowest-income workers may need to give them more generous credits (or offer Medicaid).⁴⁰

Table 4: Worker premium costs for average employer coverage, 2002

COVERED HOUSEHOLD	TOTAL ANNUAL PREMIUM	EMPLOYER PAYMENT		WORKER'S ANNUAL PREMIUM COSTS		
		DOLLARS	PERCENT OF PREMIUM	DOLLARS	PERCENT OF INCOME	
					AT 100% FPL	AT 200% FPL
<i>Worker-only</i>	\$3,060	\$2,606	85.2%	\$454	5.1%	2.6%
<i>Family</i>	\$7,954	\$5,870	73.8%	\$2,084	11.5%	5.8%

Source: Kaiser Family Foundation/HRET survey of 2002 employer coverage.⁴¹

Table 5: Worker premium costs for various FEHBP plans in 2002: Impact of tax credits

PLAN TYPE		TOTAL ANNUAL PREMIUM	MAXIMUM CREDIT		WORKER'S ANNUAL PREMIUM COSTS		
COVERAGE	PERCENTILE RANK OF PREMIUM, AMONG FEHBP PLANS		DOLLARS	PERCENT OF PREMIUM	DOLLARS	PERCENT OF INCOME	
						At 100% FPL	At 200% FPL
<i>Worker-only</i>	35th	\$2,981	\$ 2,288	76.7%	\$693	7.8%	3.9%
	50th (median)	\$3,164	\$2,407	76.1%	\$757	8.5%	4.3%
	65th	\$3,372	\$2,542	75.4%	\$830	9.4%	4.7%
<i>Family</i>	35th	\$7,523	\$5,940	79.0%	\$ 1,583	8.7%	4.4%
	50th (median)	\$7,922	\$6,199	78.3%	\$1,723	9.5%	4.8%
	65th	\$ 8,371	\$ 6,491	77.5%	\$ 1,880	10.4%	5.2%

Source: OPM, 2002.⁴² Calculations by Economic and Social Research Institute, October 2002.

Notes: (1) Credit amounts are calculated based on: (a) a fixed annual credit of \$1,000 per adult and \$500 per child, with a \$3,000 maximum per family; plus (b) 65% of premium costs above the fixed credit; but (c) not more than 90% of total premium costs. (2) For worker-only coverage, the table uses 2002 FPL for a household of one. (3) For family coverage, the table uses: (a) 2002 FPL for a household of four; and (b) maximum family credit amount. (4) FEHBP premiums are based on an unweighted ranking of 2002 FEHBP premiums for all plans also participating in FEHBP in 2003. (5) Credit amounts are not reduced or set off based on household income.

To further reduce payments required from low-income households would raise subsidies above FEHBP levels, which can be justified on two grounds. First, the true FEHBP subsidy is higher than the nominal 72 to 75 percent, because federal employees save money, depending on their tax bracket and choice of plan, by using pretax dollars to pay their share of premium costs. Second, and most important, low-income, uninsured families have less capacity to pay premiums than do most federal employees, whose average annual income exceeds \$50,000.⁴³

In addition to the subsidy level, other design features of this option encourage take-up. First, workers automatically apply for the credit unless they affirmatively opt out. Similar automatic enrollment procedures for 401(k) pension plans have dramatically increased enrollment. One study, for example, found that participation rates during the first year of employment rose from nearly 33 percent of employees before the company instituted automatic enrollment to 86 percent afterwards, with low-income workers experiencing the most dramatic increase.⁴⁴ Second, while limited benefits have often proven unpopular when

offered,⁴⁵ this approach seeks to give tax credit recipients access to more widely accepted, comprehensive coverage resembling traditional employer insurance. Third, federal credits could be designed to permit supplementation by states and private sector entities, including employers and charities.⁴⁶

This approach to tax credits avoids several problems frequently ascribed to health insurance tax credits. One set of concerns relates to the nongroup market; this option does not provide access to that market. Another concern frequently voiced is that, by attracting younger and healthier employees into less expensive and more limited non-employer plans, tax credits worsen the risk pool served by employer coverage, further driving up employers' already rising health insurance costs and potentially damaging the country's increasingly fragile employer-based system. Such concerns do not seem well-founded, however, with the eligibility groups involved in this approach: namely, the poor uninsured and moderate-income employees of very small companies. According to recent Census data, in 2001, only 3.1 percent of all Americans with employer

Should insured workers receive subsidies?

Some contend that, for finite dollars to yield the greatest possible reduction in uninsurance, credits or other subsidies should be limited to the uninsured. Others argue that, unless subsidies go to similarly situated workers, insured and uninsured alike, low-income families will be unfairly disadvantaged if they acted responsibly and bought insurance without subsidies, sometimes at considerable financial sacrifice. This question arises whether policymakers use tax credits or other subsidies to expand coverage.

To maximize equity, policymakers could make subsidies fully available for use to purchase employer coverage, including by those already insured. However, this would allocate a significant proportion of subsidies to people with insurance. Even among workers with incomes below 200 percent of FPL who are employed by firms with fewer than 10 workers, 42 percent have insurance.⁴⁷ Presumably, virtually all these employees would take advantage of subsidies, since they yield a benefit (lower net health insurance costs) without any cost to the worker. Many of the uninsured, by contrast, will not take up subsidies, since subsidies involve, not just the benefit of health insurance, but also the cost of paying the family premium share. If anything less than 72 percent of these uninsured workers take up subsidies, more than half of all subsidies will go to the already insured even among this unusually vulnerable group (low- and moderate-income employees of very small firms).⁴⁸

At the other end of the continuum, policymakers could minimize “leakage” of public dollars by barring subsidies to workers with any access to employer coverage. However, in addition to creating equity problems, this approach would deny help to uninsured, low-wage workers who either cannot afford their share of employer-sponsored insurance or are ineligible for such coverage because of part-time work, employer waiting periods, etc.

The approach described here seeks a middle ground. It covers the poor uninsured, whether or not they have access to employer coverage, since only 8.2 percent of poor Americans receive coverage from their employers (another 8.6 percent are covered by the employer of another family member).⁴⁹ Moderate-income employees of small business are not covered unless they lack access to employer coverage or would be required to spend more than 5 percent of income to purchase it. Presumably, such burdensome premium costs make this group unlikely to have employer coverage, which reduces substitution of public for private dollars. But those with coverage obtained it at considerable financial sacrifice and are a group of currently insured workers who especially deserve help.

This approach could be adjusted in either direction. Here are two examples among many of such adjustments:

- Policymakers seeking stricter safeguards preventing erosion of employer coverage could deny subsidies to workers who had employer coverage during a specified period (perhaps six months) before they applied for assistance. Many state SCHIP programs use similar waiting periods, typically with exceptions for those who lost employer coverage because of factors outside the family’s control, such as lay-offs.⁵⁰
- Policymakers who believe that the need for such safeguards is exaggerated could offer credits to workers ineligible for coverage offered by their employers. This would include recent hires affected by employer waiting periods and part-time workers.⁵¹

coverage had incomes below 100 percent of FPL. Along similar lines, Figure 2 shows that firms with fewer than 10 workers account for only 8.2 percent of all the country’s workers insured by their employers.⁵² Equally important, this approach provides tax credit beneficiaries with group coverage meeting actuarial value standards based on the most popular group plan serving federal

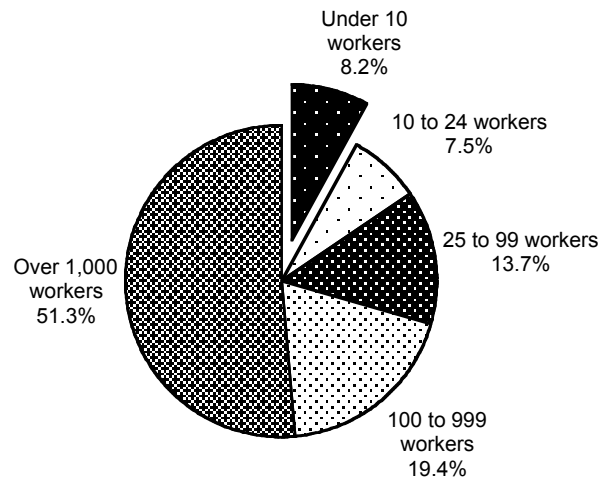
employees. Such relatively comprehensive, group coverage seems unlikely to lure large numbers of young, healthy workers away from their employers’ insurance.⁵³

Overall, this approach uses selected elements from each side of the philosophical divide, as Table 6 suggests.

Table 6: Positive Elements and Limitations of Individual Choice/FEHBP/Tax Credit Approach, as Potentially Seen by Two Different Schools of Thought

	SUPPORTERS OF TAX CREDITS, NONGROUP INSURANCE, LIMITED BENEFITS, AND STATE (RATHER THAN FEDERAL) SOLUTIONS	SUPPORTERS OF GOVERNMENT PROGRAMS, GROUP PLANS, AND COMPREHENSIVE BENEFITS
Positive elements	<ul style="list-style-type: none"> ▪ Tax credits ▪ “Largely run on the free market principles of consumer choice and market competition”⁵⁴ ▪ Prioritizes small business and workers least able to afford coverage ▪ Provides financial incentives to select less expensive coverage 	<ul style="list-style-type: none"> ▪ Broad benefits, comparable to employer-sponsored insurance ▪ Group coverage ▪ Large subsidies making coverage affordable ▪ Limited opportunity for insured workers to abandon employer coverage
Limitations	<ul style="list-style-type: none"> ▪ Only group coverage offered ▪ No access to high-deductible plans, if they fall below actuarial value standards or violate low-income cost-sharing rules ▪ A federal agency, rather than states, contracts with health plans 	<ul style="list-style-type: none"> ▪ No guaranteed benefits package ▪ No public program expansion ▪ Despite safeguards, may create risks to employer coverage and public programs

Figure 2: What proportion of all workers covered by their employers work for companies of various sizes?



Source: AHRQ, 1999 MEPS (Calculations by ESRI, 6/02).

Category Two: Hybrid Strategies

Hybrid proposals combine public program expansions with tax credits for purchasing private insurance. The following discussion explores how each component could be structured to cover many uninsured while avoiding the greatest fears of policymakers who generally prefer the other approach. It then discusses the interaction between these two components.

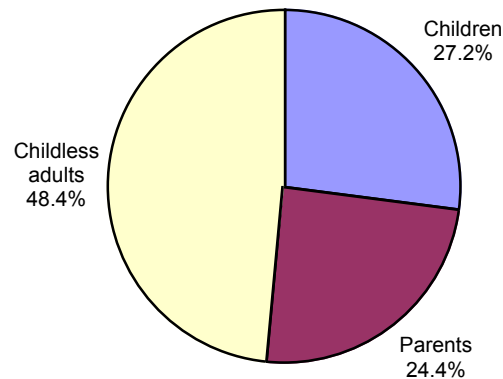
Public program expansion

Today, state Medicaid programs are required to use different eligibility rules for different groups of children, seniors, people with disabilities, parents, and other adults. One possible public program expansion addresses this complexity by creating a new option for “need-based” Medicaid. Under this approach, states can cover residents based purely on their limited income, without regard to other household characteristics.⁵⁵ States determine the percentage of the federal poverty level (FPL) under which residents qualify for such coverage,⁵⁶ as long as that level is below an upper limit set by Federal law.⁵⁷ This new category includes poor, childless adults – that is, low-income adults who are neither elderly, severely disabled, pregnant, nor caring for dependent children living at home. They now comprise the one category that state Medicaid programs generally may not cover, no matter how low the adults’ income. However, federal waivers, which require a showing that overall federal Medicaid spending will not increase, have let some states cover childless adults by limiting spending on other low-income groups.⁵⁸

Following are some advantages of this approach to public program expansion:

- It is equitable to prioritize the uninsured with the least ability to purchase coverage. Even policymakers generally resistant to government intervention sometimes support government help for those who are least able to help themselves.⁵⁹
- States receive the option to cover, without waivers, the largest single group of low-income uninsured people: namely, adults without dependent children living at home. Such childless adults now comprise 48.4 percent of all non-elderly uninsured with incomes at or below 200 percent of the federal poverty level (FPL), as Figure 3 illustrates.⁶⁰
- This approach redresses the historical accident that caused federal law to single out childless adults who are neither elderly, severely disabled, pregnant, nor parenting as the only eligibility category for which Medicaid coverage is forbidden without waivers. The exclusion of these childless adults resulted simply from Medicaid’s early association with cash assistance programs serving other populations.⁶¹
- This approach also permits states to remedy the inequity of denying Medicaid to low-income workers based simply on the absence of a child or pregnancy in the home. A state could make simple inability to afford coverage, rather than the presence of children at home or other household characteristics, the touchstone of Medicaid eligibility. States receive the option to simplify

Figure 3: Low-income, Non-elderly Uninsured (Less than 200% of Poverty): 2000



Source: Kaiser Commission on Medicaid and the Uninsured, February 2002. Calculations by ESRI (6/02).

Medicaid by covering residents based simply on limited income.⁶² States would not need even to consider other eligibility categories or to apply their varying and complex rules unless applicants fail to qualify for need-based Medicaid. Unlike many other incremental strategies, this approach would integrate expanded with existing coverage to create a simpler overall system. (Of course, multiple eligibility categories would still be needed for individuals with incomes too high for need-based coverage.)

- If federal policymakers chose to offer enhanced federal matching funds for need-based Medicaid, as described below, states would be encouraged to cover, not just childless adults, but also low-income parents previously ineligible for Medicaid. While current law lets states cover such parents without waivers, federal match is offered at standard Medicaid levels, rather than the higher amounts available for SCHIP children.⁶³ Most states thus do not give parents anywhere near the coverage available to children. For example, the median state covers children with family income up to 200 percent of FPL (now \$2,438 a month for a family of three) but parents up to only 69 percent of FPL (\$836 a month for such a family).⁶⁴ Covering low-income parents both improves their access to health care and makes it more likely that they will enroll their children and use coverage effectively.⁶⁵

This approach is structured to ameliorate, at least in part, the following concerns of those who generally oppose public program expansions:

- “Medicaid gives states little flexibility.” This approach offers states an additional option, not a new federal mandate. States can shape their implementation of this option by setting income levels or using income levels to phase in

expanded coverage. Moreover, the new state option enhances state flexibility by making waivers unnecessary for states that wish to cover childless adults. This means that states, not federal officials, decide whether to fund coverage of low-income, uninsured residents by (a) cutting spending on health care for other residents or (b) using different financing mechanisms preferred by the state.⁶⁶

- “Medicaid crowds out employer-based coverage.” Concentrating resources on the poorest uninsured reduces crowd-out risks, because lower-income individuals are less likely to have employer coverage.⁶⁷

- “Medicaid is a stigmatized program inappropriate for most working uninsured.” By targeting the lowest-income uninsured who are currently ineligible for Medicaid (including poor, childless adults), this approach selects a group that even many who are generally uncomfortable with Medicaid may agree is appropriate for Medicaid’s model for delivering care. Unlike most conventional private insurance, Medicaid limits cost-sharing to nominal levels affordable to poor households. For many beneficiaries, it also provides a generous benefits package that recognizes the inability of poor people to pay for uncovered services out of pocket. Such benefits include services for people with special health care needs (including mental health and substance abuse problems) and services like transportation and community health center care that are particularly important to many low-income people.⁶⁸

Of course, this approach, like all policies, has disadvantages:

- Some states implementing this option may use federal funding, not just to expand coverage, but also to replace state dollars currently spent for indigent care, reimburse

How can states be encouraged to implement this option?

Some policymakers may fear that many states will not implement this new option, because it requires state matching funds. To address this concern, policymakers could use SCHIP's model of providing significantly enhanced federal matching rates⁶⁹ for beneficiaries of expanded coverage who would not have qualified for Medicaid or SCHIP under previous state law.⁷⁰ This strategy would seek to replicate, as much as possible, SCHIP's track-record of broad state implementation and increased coverage of low-income children.⁷¹ Under a second and generally simpler approach, a state covering all legal residents up to a specified income level (for example, 100 percent of FPL) and implementing certain outreach methods and application simplifications (such as short forms that can be submitted by mail) could receive enhanced federal matching rates (somewhere between Medicaid and SCHIP levels) for all Medicaid beneficiaries, not just the new, need-based group.⁷²

Policymakers pursuing either approach need to include safeguards ensuring that new federal dollars are used to expand coverage significantly, not just to provide state fiscal relief. Without such safeguards, a state could obtain increased federal funding for existing beneficiaries while limiting new state costs by keeping to a minimum the number of uninsured who receive expanded coverage.⁷³

With either approach, policymakers could also apply another feature of SCHIP that apparently contributed to broad implementation: namely, defined, annual allotments of enhanced matching funds for each state, with unspent amounts redistributed to other states. Some state officials implemented SCHIP expansively in part to avoid the embarrassment of returning "their state's money" to the federal government.⁷⁴ On the other hand, SCHIP allotments do not "follow the children" and correspond precisely to varying state circumstances. This is one reason why some states exhaust their SCHIP grants mid-year, while others have difficulty spending more than a fraction of their allotments on uninsured children.⁷⁵

Policymakers wishing to incorporate this aspect of SCHIP⁷⁶ could, under any definition of the group entitled to enhanced match, give each state an annual allotment of enhanced funding. As with states that implement SCHIP through Medicaid expansions,⁷⁷ if a state spends its allotment of enhanced funds before the end of the year, federal match would revert to usual Medicaid levels until the following year; and a state failing to spend all of its allotment would forfeit the remainder to other states.⁷⁸

ment for hospital charity care and bad debt, inpatient and outpatient mental health care, and substance abuse treatment.⁷⁹

- Medicaid has some disadvantages. Although recent years have seen important improvements,⁸⁰ and programs vary greatly among states, Medicaid application and retention procedures tend to be complex and diffi-

cult for adults;⁸¹ provider reimbursement rates are being cut in many states experiencing budget problems;⁸² and some mainstream health insurers have left the program in a number of states.⁸³ Analysts disagree about whether certain other features of Medicaid—such as the requirement that states must enroll all eligible applicants, with federal matching funds guaranteed—are advantages or disadvantages.

This approach is not the only possible public program expansion, of course. For example, it could be modified slightly by defining the new, optional eligibility category to include only childless, non-disabled, non-elderly adults, the one group for which standard Medicaid match is unavailable as a state option today.⁸⁴ Policymakers who wish to encourage state implementation, as discussed above, could offer enhanced federal match for this more narrowly defined group. Compared to need-based Medicaid, this category would offer states fewer opportunities to "game" the system. Simpler federal safeguards accordingly could apply, requiring only modest changes to standard Medicaid quality control procedures.⁸⁵ Counterbalanced against such policy simplifications are several disadvantages: this more targeted approach does not encourage states to cover low-income parents currently ineligible for Medicaid; and it gives states a less powerful tool to simplify eligibility categories.⁸⁶

Several other, quite different public program expansions have been discussed in Congress and merit serious consideration. Policymakers could give states the option to cover, through Medicaid and SCHIP, legal immigrants who arrived in the United States after 1996.⁸⁷ Also, SCHIP grant levels could increase and states could be allowed, without federal waivers, to extend SCHIP to low-income, uninsured parents along with their children.⁸⁸ In addition, Medicaid and/or SCHIP could allow the families of children with disabilities to "buy in" on a sliding scale up to 250 percent of FPL.⁸⁹

Tax credits to buy private insurance

The second component of this particular hybrid strategy uses tax credits to subsidize the purchase of private insurance. Fewer resources are available for such credits than under the tax credit policy described in Category One. Accordingly, credit eligibility is more limited, reaching only low- and moderate-income workers (such as those below 250 percent of FPL) at small companies (for example, those with fewer than 10 employees) that either do not offer insurance or require workers to contribute a premium share that exceeds a certain proportion (perhaps 5 percent) of household income. As with the policy described in Category One, workers are required to apply within a certain period of initial hiring into a job qualifying for credits.

This approach limits costs by controlling eligibility, rather than lowering credit amounts. This gives tax credits a fair and safe test: fair because credits are large enough that they can succeed in reaching the target group; and safe because a careful choice of the target group can lessen or prevent many dangers feared by tax credit opponents, as explained below.

Two other changes to the tax credit approach in Category One are needed, given the absence of FEHBP-type purchasing and consumer information systems under this hybrid approach. First, credits can be used in any market accessible to the beneficiary under state and federal law, including the nongroup market, employers, former employers covered by COBRA or state mini-COBRA laws, other affinity or employer groups offering insurance,⁹⁰ and state pools.⁹¹ In addition, one or more “fallback” plans offer coverage at least equal in actuarial value to the most popular plan serving federal employees, with premiums that cannot exceed what that plan charges for federal workers. The federal government contracts with one or more such plans, either nationwide⁹² or specifically for states in which plans meeting the same criteria are unavailable for workers without access to employer coverage. Federal funds pay for financial incentives or guarantees to insurers (such as reinsurance, stop-loss protection, or risk adjustments) needed to keep premiums at or below the levels charged for federal employees.

Second, each credit is coupled with a small payment for insurance brokers or other information providers to help the credit beneficiary navigate our increasingly complex health care system and choose a plan. To assure that advice funded by such a payment is not influenced by conflicts of interest, the broker or provider must, to obtain the payment, agree not to accept other reimbursement for the tax credit beneficiary that varies based on which plan the beneficiary chooses.

Such tax credits are structured to address some of the concerns expressed by skeptics:

- “Tax credits disproportionately benefit the currently insured rather than the uninsured.” This particular approach focuses resources on a group likely to be uninsured – namely, low- and moderate-income workers at small companies. For example, at firms with fewer than 10 employees, 63 percent of workers with incomes below 100 percent of FPL are uninsured, as are 56 percent of those between 100 and 200 percent of FPL.⁹³ The proportion of credits subsidizing already insured workers is further reduced by denying credits to workers offered employer coverage whose premium share falls below 5 percent of family income.
- “Tax credits involve adverse selection. Healthier beneficiaries will stay out of either more generous plans or tax credits altogether, leaving behind a more expensive population, which increases premiums for remain-

ing, less healthy enrollees.” Several factors limit adverse selection under the approach described above. First, beneficiaries are prohibited from waiting until they get sick before seeking credits; they must enroll within a certain period after starting a job qualifying for credits. Second, more generous subsidies may reduce adverse selection, since cutting family premium obligations reduces a healthy worker’s financial gains from remaining uninsured or choosing less expensive coverage. Third, if adverse selection occurs into comprehensive coverage, national fallback plans protect beneficiaries from premium increases, since premiums are capped based on costs for federal employees, with the federal government providing plans with financial incentives and guarantees to keep premiums below the cap.^{94 95}

Following are some disadvantages of this approach to tax credits:

- Limiting subsidies to workers at small companies creates inequities. It disadvantages other uninsured with just as little income and just as much need for health coverage but who are unemployed, self-employed, or work in low-wage jobs for larger companies.
- Some small employers may not wish to assume new administrative responsibilities,⁹⁶ even if their workers benefit from the resulting health insurance tax credits. Although such employers are responsible for payroll withholding today and this approach would simply add one new withholding category, there may be some administrative burden even among the many small firms that now use inexpensive software or contract with business accounting firms to handle their workers’ paychecks.⁹⁷
- Allowing credits to be used in the nongroup market raises some concerns that are not addressed by the guaranteed availability of comprehensive, group coverage through national back-up plans. Despite subsidies for comprehensive coverage, some young and healthy workers may choose inexpensive plans with high cost-sharing and limited coverage, which trouble some analysts for reasons described below; and a higher proportion of public dollars will pay for administrative costs.
- It could distort labor markets modestly by encouraging employment at small firms, since larger ones do not qualify for credits.

In addition to helping some uninsured afford coverage, this scaled-back tax credit approach has the purpose of obtaining information that could help guide the design of future expansions. This is particularly important given the country’s limited experience with health insurance tax credits.⁹⁸ Although findings about small firms may not necessarily generalize to other companies, the suggested tax credit approach could nevertheless provide new information to help resolve current uncertainties. Topics potentially illuminated by implementation of health insurance credits for low- and mod-

erate-income employees of small business include take-up rates, crowd-out of employer coverage, the operation of advanceable, refundable, and non-reconcilable health insurance tax credits, adverse selection and risk segmentation, the operation of subsidies in the nongroup market, default enrollment mechanisms, and the appeal of limited vs. comprehensive coverage. In addition, this approach would test whether an effective market can be created for services, offered either by employers, insurance brokers, or others, to help consumers navigate an increasingly complex health coverage system.

Perhaps with some supplementation for the lowest-income beneficiaries, the credits discussed here could also help us learn whether subsidies that make both more and less comprehensive coverage affordable (albeit with some savings the worker realizes from choosing more limited plans) lead most young, healthy workers to choose comprehensive rather than more limited coverage.

On the other hand, some policymakers may resist undertaking such an experiment with billions of dollars in public funds. As indicated above, those who prefer not to subsidize current beneficiaries of employer coverage could safeguard the employer-based system by denying credits to some or all workers offered insurance by their employers or their spouses' employers.

This tax credit strategy could be modified in several ways. For example, credits could go to small employers,

rather than their workers, as suggested by a number of analysts.⁹⁹ That would strengthen, rather than threaten, employer-based insurance. On the other hand, such a modification would deny coverage to workers at small companies that decline to offer coverage, despite credits, because of the administrative hassles of managing health coverage or other reasons.¹⁰⁰ It would also foreclose access to the nongroup market, which may reassure some policymakers but trouble others. To date, employer credits and other subsidies at the state level have helped few uninsured, perhaps because of limited funding, small credits, and inadequate outreach.¹⁰¹

Another variation would base credit eligibility not just on firm size but on some combination of size and proportion of employees in low-wage jobs. For example, credits could go, not just to workers at companies with fewer than 10 workers, but also to those where at least 50 percent of employees earn low wages. Table 8 compares health insurance coverage at these two intersecting¹⁰² groups of firms.

Other, relatively modest variations¹⁰³ would extend credits to low-income workers at slightly larger firms or base credit eligibility entirely on firm size, without regard to income. Table 9 shows that, as employer size increases, the proportion of uninsured workers drops and the percentage with employer-based insurance increases.

Limited vs. comprehensive benefits: what's the right policy goal?

Some proponents of health coverage expansion contend that subsidies should finance relatively comprehensive benefits, comparable to traditional employer-sponsored insurance (ESI). Others advocate more limited coverage with higher cost sharing, such as high-deductible plans.¹⁰⁴ Table 7 lists some of the main arguments on both sides of this debate. The tax credit approach suggested here seeks to provide affordable access to both types of coverage.

Table 7: Arguments favoring subsidies for limited vs. comprehensive benefits

LIMITED BENEFITS, WITH HIGH COST-SHARING	COMPREHENSIVE BENEFITS, WITH LOW COST-SHARING
<ol style="list-style-type: none"> 1. Controls costs by increasing consumers' incentive to limit their use of services. 2. Health coverage more closely resembles true insurance, which protects against large and unforeseeable losses. 3. By lowering per capita cost of coverage, increases the number of uninsured who can be helped with a fixed amount of funding. 4. Coverage of catastrophic costs addresses the worst financial consequences of uninsurance. 5. By offering less coverage than ESI, reduces employees' incentives to leave ESI for subsidies. 6. High cost-sharing tries to control health spending without HMO-style limits on provider networks and covered services. 7. It makes sense to begin with basic benefits, adding more coverage if revenue grows or individuals are willing to pay more. 	<ol style="list-style-type: none"> 1. Achieves medical advantages of coverage by encouraging early detection and treatment of illness. 2. High cost-sharing causes even middle-income consumers to avoid both necessary and unnecessary care. 3. High cost-sharing causes low-income consumers, particularly adults with chronic illness and children, to defer care, sometimes suffering serious health harm. 4. When offered limited benefit plans, very few employers or individuals have enrolled. 5. Individuals buying uncovered care can pay inflated charges that exceed prices paid by insurers, which have the trained staff and leverage to extract concessions from providers. 6. Unlike individuals buying uncovered care, plans can monitor providers' quality of care using data about services to multiple patients and can use payment arrangements to reward quality care.

Table 8: Employer coverage at small firms vs. low-wage firms

	NUMBER OF WORKERS (MILLIONS)	PROPORTION OF WORKERS IN SUCH FIRMS OFFERED COVERAGE BY THEIR EMPLOYER	PROPORTION OF WORKERS IN SUCH FIRMS COVERED BY THEIR EMPLOYER
<i>Firms under 10 workers</i>	15.1	52.4%	34.8%
<i>Firms with 50% or more low-wage workers</i>	7.5	63.1%	18.8% ¹⁰⁶

Source: AHRQ, 1999 MEPS (Calculations by ESRI, 7/02). Note: for the 1999 MEPS survey, low-wage jobs were defined to pay \$6.50 an hour or less.

Table 9: Health coverage at small firms of various sizes

FIRM SIZE BY NUMBER OF WORKERS	TOTAL NUMBER OF WORKERS NATIONALLY (MILLIONS)	UNINSURED WORKERS		WORKERS COVERED BY OWN EMPLOYER		WORKERS COVERED BY EMPLOYER OF SPOUSE OR OTHER FAMILY MEMBERS	
		Number (millions)	Percentage of workers at such firms	Number (millions)	Percentage of workers at such firms	Number (millions)	Percentage of workers at such firms
<i>Under 10</i>	19.4	6.0	31%	7.0	36%	4.8	25%
<i>10 to 24</i>	12.8	2.9	23%	6.4	50%	2.6	20%
<i>25 to 99</i>	17.3	2.9	17%	10.7	62%	2.8	16%

Sources: Garret and Nichols, Urban Institute, August 2001 (analysis of February and March 1999 CPS data). Monthly Labor Review, April 2000 (analysis of March 1999 CPS data). Calculations by ESRI, 7/02.

Notes: (1) In each row, the percentages do not add up to 100, because some workers are covered through public programs or the nongroup market, neither of which is included in this table. (2) Because they involve slightly different comparisons, Tables 8 and 9 are based on two different government surveys: MEPS and CPS, respectively. Accordingly, the two tables have somewhat different numbers for firms with fewer than 10 workers.

The interface between public programs and tax credits

Under a tax credit approach, states facing budget problems could have an incentive to save money by shifting beneficiaries from Medicaid or SCHIP, which states partially fund, into tax credits funded at no state cost. Defenders of public programs may fear resulting harm to vulnerable beneficiaries who need public programs' special protections, such as those discussed above. Moreover, if states "dump" current enrollees into tax credits, federal funds intended to cover the uninsured would, instead, provide state fiscal relief by substituting for previous state spending on Medicaid and SCHIP.

On the other hand, some argue that public programs like Medicaid, in many states, have serious problems, also discussed above. At a minimum, according to this view, beneficiaries with higher incomes should have the choice to enroll into more mainstream insurance.

Here is one possible approach to resolving this issue:

- Tax credits could be denied to individuals with income under a certain cut-off point who qualify for Medicaid or SCHIP under current law. States might have the discretion to vary that cut-off somewhat. These public programs' complex eligibility rules probably require applications to be submitted automatically when-

ever tax credit applicants with incomes below the cut-off point are not plainly ineligible for Medicaid or SCHIP; a similar "screen and enroll" requirement applies today under SCHIP.¹⁰⁷

- Individuals with incomes above the cut-off point who qualify for both tax credits and public programs could choose to enroll in any health plan available through either of these programs. If people eligible for public programs choose the plans serving tax credit beneficiaries, public programs would offer "wrap around" payment for services and costs not in the coverage purchased by credits.

- Each state could be required to pay its share of the Treasury's tax credit costs for state residents who qualify for Medicaid or SCHIP.¹⁰⁸ Implemented effectively,¹⁰⁹ this could eliminate states' financial incentives to "dump" public program enrollees into tax credits. The Center for Medicare and Medicaid Services could determine each state's repayment amounts by examining a small but representative sample of state residents receiving tax credits, applying standard procedures used for decades to determine Medicaid eligibility error rates.¹¹⁰

Category Three: State-based strategies

To bridge policymakers' philosophical differences, the final major approach discussed in this paper provides health insurance grants to states, which can choose from a menu of expansion options. The following sections explore, in turn, the options from which states can choose; the requirements states are asked to meet; trade-offs policymakers pursuing this approach may need to resolve; and methods to promote state accountability.

Menu of state options

The following are choices policymakers could consider offering states:

- **Public program expansions** to groups Medicaid and SCHIP did not previously cover in the state. For states to have the ability to use these new grant funds to expand public programs and reach the many low-income uninsured who are childless adults, they need the additional Medicaid eligibility options described above in Category Two. Until exhausted during a given year, grant funds could pay some or all of a state's costs of covering new groups under these federal-state programs.¹¹¹
- **Refundable, advanceable tax credits** to individuals. Many states have their own income tax systems that could deliver such credits. Other states could use health insurance vouchers that simulate the effect of federal tax credits.
- **Financial support to employers** for expanded health coverage, through tax credits or other subsidies.
- **Restructuring** health care markets using such strategies as purchasing cooperatives, high-risk pools, and market reforms. Grant funds could pay start-up and administrative costs for purchasing cooperatives and other strategies, subsidize losses experienced by high-risk pools, etc.
- **Buy-in** options permitting individuals and groups (perhaps including firms) to enroll in plans offered through Medicaid, SCHIP, or public employee programs. Buy-in costs could be adjusted based on ability to pay.
- **Multi-state strategies** permitting states to join together and address common problems that cross state lines or to pool their purchasing power to obtain better prices from providers, suppliers, or health plans.
- **Local or regional strategies**, allowing a state to pilot test expansion strategies in part of the state, to help geographic areas hard-hit by layoffs or with particular health access problems, to work with units of local government willing to commit resources to coverage expansion, etc.

- **Other approaches** proposed by a locality, a state, or a combination of states. Some states have already developed innovative, state-specific plans for expanded health coverage. Approaches outside the more narrowly defined menu of state choices could be approved for a defined period, up to, for example, three years. After that initial implementation, a state could perhaps continue such an approach indefinitely, but only if HHS certifies that the state has met statutory criteria chosen by federal lawmakers (such as a certain reduction in the proportion of uninsured residents, absence of harm to employer-sponsored coverage, continued enrollment levels in prior Medicaid and SCHIP coverage categories, etc.).

States already innovating

Since SCHIP's enactment, new federal resources for coverage expansion have been largely limited to the Health Resources and Services Administration's state planning grants.¹¹² By sparking planning processes in many states, these grants (and related foundation funding)¹¹³ are laying the foundations for possible future state reforms that could make a significant dent in the number of uninsured. Despite pressing fiscal limitations, a number of states have gone beyond planning to implement innovative approaches to coverage expansion, which could be used to further develop a menu of state options for a new health insurance grant program. Here are two examples from very different states:

- **Massachusetts** has instituted several programs to help employers and workers pay their respective premium shares for employer-based insurance. State officials report that this program covers 12,000 individuals and that employer offers of health insurance, which had been declining steadily for a decade, have not only stabilized but increased since implementation of premium support programs.
- **Arkansas** plans to combine a substantial Medicaid expansion financed by tobacco settlement funds with multifaceted support for small employers, including a Medicaid buy-in option, local purchasing pools, and risk pools to stabilize coverage.

New Mexico, Rhode Island, Vermont, New York, and other states have likewise been developing and implementing innovative expansion proposals.¹¹⁴

Standards for approving state plans

Under typical state-based approaches, states propose plans to a federal agency, which evaluates them based on national standards. In this case, such standards could address topics like the following:

- **Fiscal integrity.** Strong safeguards, perhaps including maintenance-of-effort-requirements for coverage, outreach, and procedural streamlining in public programs, may be needed to prevent the kind of innovative state

strategies that, in Medicaid, have sometimes diverted federal funds away from their intended beneficiaries and into unrelated state activities.¹¹⁵ Policymakers need to consider whether Medicaid's fiscal integrity requirements can be applied to this more flexible grant, as they were to SCHIP.¹¹⁶

- **Covered benefits.** States could be required to cover (or at least make available at an affordable price) a minimum level of benefits. To maximize state flexibility and potential responsiveness to changes both in medical technology and health care markets, benefit requirements could be stated (at least in part) in terms of actuarial value, rather than specific services.¹¹⁷ The SCHIP statute took a similar approach. As discussed below, policymakers contemplating this approach need to resolve tradeoffs between maximizing state flexibility and guaranteeing that beneficiaries receive essential services.

- **Costs to low-income beneficiaries** would need to be limited, for both premiums and out-of-pocket co-payments and deductibles.

- **Quality of care** would need to meet minimum standards to ensure that beneficiaries receive necessary care. Such standards could address such issues as access to providers, solvency, reporting on core quality indicators, and safeguards to reduce medical errors.

- **Choice** of health plan options would give plans incentives to increase market share by providing good care and customer service.¹¹⁸ For example, the recently enacted grant program for state high-risk pools requires that, for a state to receive such a grant, its pool must offer enrollees a choice of at least two plans.¹¹⁹

- **Safeguards to preserve employer-sponsored insurance** may be needed for states subsidizing coverage at income levels where such insurance predominates (for example, above 150 percent of FPL).

- **Safeguards to preserve prior public coverage**, such as those discussed above, may be needed as well.

- **Limits on administrative and other non-coverage costs** may be important. Many states have objected to federal rules permitting only 10 percent of SCHIP funds to be spent for purposes other than coverage. However, some such limit (perhaps restructured)¹²⁰ is needed to ensure that new health insurance grants result in significant coverage expansion and are not diverted to other purposes.¹²¹

- **Eligibility rules** may need federal parameters defining the range of permissible state options. For example, when can states cover higher-income beneficiaries while leaving lower-income uninsured ineligible for assistance? Some policymakers might prefer, given limited federal funds, to give states the option to carve out discrete groups for more intensive assistance, even if such groups include some with comparatively high incomes.

Should states be barred from using grant funds on behalf of particular immigrant groups, such as recent arrivals in the United States?¹²² Will states be authorized to use grant funds to provide undocumented immigrants and others who remain uninsured with specific services, such as detection and treatment of communicable disease, emergency care, disease management for specific chronic illnesses, and prenatal care?

To simplify the process for states to obtain approval of their coverage expansion plans, certain state policies could be deemed to meet specific requirements. For example, coverage for state or federal employees or non-waivered Medicaid or SCHIP health plans could automatically satisfy benefits and quality requirements.¹²³ Likewise, a state that expanded Medicaid or SCHIP could automatically meet grant standards addressed by those programs' governing federal statutes, which include safeguards for fiscal integrity, benefits, costs, quality, and many other matters.

Trade-offs in federal legislative design

Federal policymakers pursuing this approach will need to resolve various trade-offs. Perhaps the most basic involves accountability versus flexibility. National standards ensuring that federal grants achieve certain policy goals can limit state flexibility. For example, Medicaid is more prescriptive than SCHIP about covered benefits for children. While state flexibility under SCHIP encouraged widespread state implementation, some SCHIP children with special health care needs may have been denied important services guaranteed under Medicaid.¹²⁴

As noted above, another trade-off involves whether grant funds are limited to the uninsured (to maximize coverage) or can be used to lighten the financial burdens of insured, low-wage workers (to treat individuals more fairly). Federal policymakers face a similar trade-off between coverage and equity to states. More uninsured get help if federal grants provide new coverage rather than simply replace previous state spending.¹²⁵ But if federal funds cannot cover people eligible under previous state law, the very states that have done the most to cover the uninsured will be the most severely limited in their use of these new federal dollars. A similar policy forbidding the use of SCHIP funds for children eligible for Medicaid under prior state law generated vociferous complaints from a number of states. Future state expansions may be chilled if a second federal grant program for the uninsured follows SCHIP's lead on this issue.

A related question is whether these grants should be limited to uninsured residents *ineligible* for coverage available under prior state law. States could be permitted instead to use grants to finance new outreach measures and streamline administration of existing programs, thereby reducing the number of uninsured resi-

dents eligible for but not enrolled in such programs.¹²⁶ Under one possible compromise, if all of a state's uninsured residents with income up to a certain level qualify for coverage meeting or exceeding SCHIP standards for benefits and affordability, and the state implements specified procedural simplifications, the state could use new grant funds for measures to cover uninsured residents eligible for but not yet enrolled in previous Medicaid, SCHIP, or other state coverage.¹²⁷

Finally, policymakers will need to decide the extent (if any) of state matching requirements. Nationwide, rapid, and thorough implementation of new health insurance grants may require dispensing (either largely or entirely) with state matching requirements. This is particularly true during the current economic downturn, which has caused serious budget problems in many states.¹²⁸ On the other hand, matching requirements give states incentives to control costs and promote efficiency. Reduced or eliminated state matching requirements would be one of several factors requiring other strategies for promoting state accountability under a new federal grant program.

How federal policymakers resolve these trade-offs could affect the funding formulas used to distribute these new federal grants. A tremendous challenge facing advocates of state health insurance grants is the prospect of formula fights between representatives of various states, many of whom would approach such battles with great sophistication after recent years' experience with SCHIP.

Accountability strategies

Federal policymakers pursuing a state-based approach need to decide how they will hold states accountable to meet the requirements and achieve the objectives of a new health insurance grant program. Potential accountability strategies from which such policymakers could choose include the following options:

- **Information.** States can be asked to provide HHS and make publicly available, as under SCHIP,¹²⁹ annual reports describing state policies and results, data on spending and services, and periodic, state-sponsored program evaluations. The SCHIP statute's simple requirement of state and HHS evaluations led to a significant development of information standards for children's health care that has improved consumer choice, provider practices, and state policy.¹³⁰ In addition, during the grant program's first years, HHS could be directed to study intensively states' varying approaches to increasing coverage. Such studies might include a certain minimum number of states implementing particular strategies. To guard against overwhelming states with multiple, overlapping information requests, federal policymakers could pull together existing information requirements into more integrated systems that would

also include additional elements necessitated by a new federal grant program for the uninsured. Congress could also, in statute, request (and fund) an independent, national evaluation of the new program by GAO or other, comparable experts. Not only would these steps promote accountability, they would provide important information to guide future coverage expansions at federal and state levels.

- **Transparency.** The public cannot hold states accountable unless their policies are publicly available. HHS rules and decisions likewise need to be publicly available, including through the internet. Such transparency requirements need to apply whether state plans or waivers are involved. As with SCHIP, federal statutes could require state plans to describe specific policy elements, such as outreach strategies and integration of new coverage systems with preexisting systems of public and private coverage.¹³¹

- **Financial incentives.** Targeted federal incentive funds could encourage positive state action. For example, as with the TANF program, bonuses could reward states achieving specified, measurable outcomes (such as a reduction in the level of uninsurance, avoiding losses in employer coverage, measurably increasing access to health care, etc.). Similarly, supplemental grants could help states that subject their policies to intensive and independent evaluation. Higher match could also encourage particularly difficult or productive undertakings, such as certain strategies or target populations for outreach and enrollment. More fundamentally, aligning states' financial incentives with program goals could reduce the need to apply more coercive methods to hold states accountable.

- **Goals and objectives.** The SCHIP statute tried this approach, requiring states to set strategic objectives, with performance goals and measures.¹³² Such benchmarks have been incorporated into the annual state SCHIP reports, described above.

- **Notice and appeal.** To promote fair, open, and accurate decision-making, consumers need notice of state decisions about their health coverage and the opportunity to challenge decisions they believe are wrong. Medicaid, which uses informal procedures that nevertheless satisfy exacting consumer protection requirements, may furnish a useful model in this area.¹³³

- **Federal enforcement.** Oversight by federal agencies is important but unlikely to be sufficient, given limits on resources and political factors that often constrain federal officials' ability to hold states accountable. Paradoxically, federal authority to apply modest sanctions (for example, by reducing, rather than eliminating, federal matching funding) can make federal oversight more effective; drastic sanctions, like complete defunding, have little credibility because they are used rarely if ever.

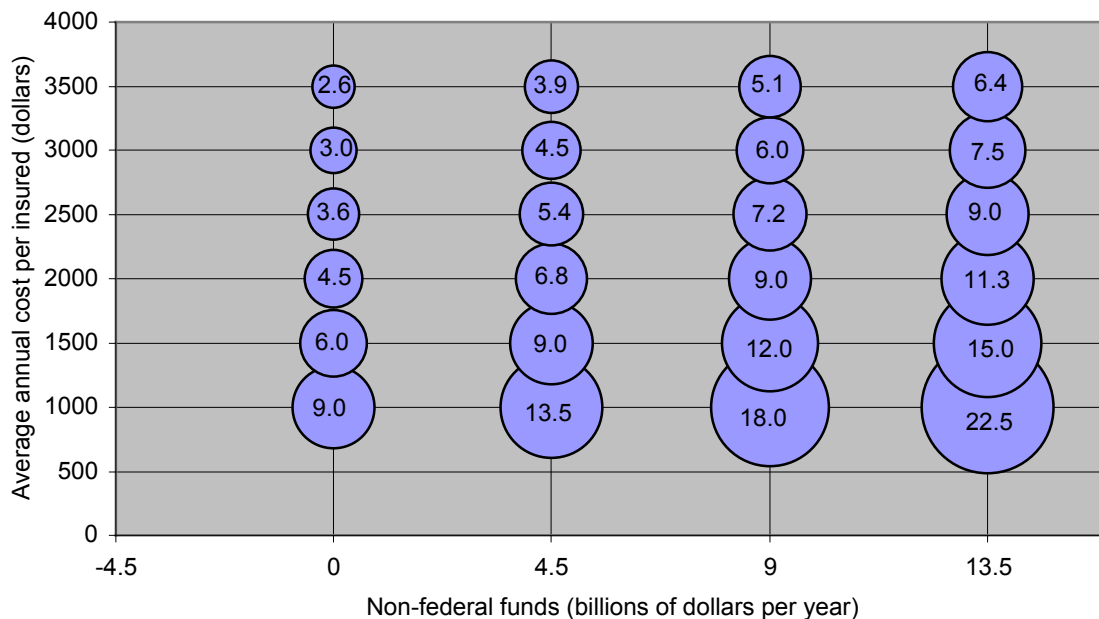
Making new dollars go farther

With any of the three general approaches discussed in this paper, federal funding can be leveraged to cover more uninsured, in several ways. First, some complementary expansion strategies increase revenue. For example, households with annual income above \$75,000 could be required to prove they have health insurance to obtain certain tax benefits (such as personal exemptions). While generating revenue, this would also encourage coverage by those with the resources to purchase insurance. In 2001, 6.6 million people with annual income above \$75,000 were uninsured,¹³⁴ which suggests the potential impact of such incentives. Second, expanding coverage may reduce the need for funding, like Medicare and Medicaid DSH, premised on a certain level of uninsurance. Third, expansions can be structured to encourage or require others to add resources, such as employers, beneficiaries asked to pay partial premiums, and (except for the first category described above) states. Figure 4 shows the potential impact of such added resources.

Such policies must be structured carefully, however, to avoid unintended harm. For example, ending personal income tax exemptions for uninsured people with comparatively high incomes may unfairly harm such people with chronic illness who cannot buy coverage because they are charged unaffordable premiums. Similarly, poorly designed cuts to DSH funding can damage the fragile health care infrastructure on which many low-income communities depend. And asking too much of employers, states, or beneficiaries can reduce, rather than expand, their participation in coverage systems.

Figure 4: Maximum number of individuals receiving coverage (millions)

Inside each circle is the maximum number (in millions) potentially covered for various combinations of (a) average cost per insured; and (b) total non-federal funding added to \$9 billion in annual federal dollars.



Notes: (1) Average annual cost per insured will be affected by such factors as generosity of covered benefits, proportion of premiums covered by subsidies, and new dollars substituting for spending on existing coverage. (2) The specific numbers for (a) average annual cost per insured and (b) non-federal funding levels are hypothetical examples intended to illustrate the general impact of these two variables on maximum possible coverage. (3) To illustrate maximum possible coverage levels, the chart assumes all funds purchase coverage.¹³⁵

• **Individual enforcement.** With current public programs, judicial review has been an important tool for reversing state policy and individual decisions that were found incompatible with federal requirements.¹³⁶ Not surprisingly, states sometimes complain about their exposure to such lawsuits.¹³⁷ One question for federal

policymakers is whether vulnerable individuals harmed by arguably illegal state policies should retain the ability to seek judicial orders requiring states to follow federal law.

Under a new federal grant program, federal agencies could also offer states non-financial support that makes

success more likely and reduces the need to take more painful accountability measures. Federal agencies could provide information about evolving state policies and best practices; bring state policymakers together on a regular basis to share ideas and meet with leading national thinkers and federal policymakers; deepen federal surveys pertaining to health coverage so that information about each state is more reliable, multi-faceted, and current; and sponsor independent research on topics of broad interest to state policymakers, such as affordability, take-up rates, crowd-out of employer coverage, the impact of various benefit designs, the effect of different cost-sharing levels on various populations, adverse selection, etc. Such steps would make strategic investments of targeted and limited federal resources to leverage significant policy improvements at the state level across the country.

Conclusion

Since the collapse of national health reform in 1994, policymakers have adopted several incremental reforms at the national level. Each measure—portability legislation (HIPAA), SCHIP, and TAA health insurance tax credits—received bipartisan sponsorship. Each was the product of compromise on all sides. This history suggests that supporters of incremental but significant

health coverage expansions may be more likely to succeed with proposals that both represent sound policy and offer prospects of broad-based support.

Stan Dorn is a Senior Policy Analyst at the Economic and Social Research Institute. Jack Meyer is ESRI's founder and President. The authors would like to thank health policy consultant Walton Francis; Robert E. Moffitt of The Heritage Foundation; James Morrison of Morrison Associates; and Len M. Nichols of the Center for Studying Health System Change; as well as Tanya Alteras, Sharon Silow-Carroll, Emily Waldman, and Elliot K. Wicks of ESRI; and, of course, our three Special Contributors, Stuart M. Butler of The Heritage Foundation, Lynn Etheredge of George Washington University's Health Insurance Reform Project, and Alan Weil of the Urban Institute, for their many helpful comments. Of course, none of these advisers is responsible for the final contents of this paper.

Covering America promotes serious consideration of a diverse range of comprehensive proposals to provide affordable health coverage for millions of uninsured Americans. The *Covering America* project is coordinated by the Economic and Social Research Institute, a non-profit, nonpartisan research institute in Washington, D.C., and is made possible by a grant from the Robert Wood Johnson Foundation, Princeton, New Jersey.

Notes

1 U.S. Department of the Treasury. *General Explanations of the Administration's Fiscal Year 2003 Revenue Proposals*, February. 2002. <http://www.treas.gov/press/releases/reports/bluebk02.pdf>.

2 *Concurrent Resolution On The Budget, FY 2003*, Report Of The Committee On The Budget, United States Senate, To Accompany S. Con. Res. 100. April 11, 2002. <http://www.senate.gov/~budget/democratic/chairmansmark/report107-141.pdf>. This version of the Budget Resolution did not commit to any particular policy for expanding coverage. Moreover, the precise amount spent for coverage expansion could vary, under this Budget Resolution, depending on spending for Medicare prescription drugs and revenue offsets. Unlike budget proposals from the Administration and the Senate Budget Committee, the House-passed Budget Resolution included no provision to help the uninsured. *Concurrent Resolution On The Budget For Fiscal Year 2003*, House Budget Committee Substitute. <http://budget.house.gov/03substitute.pdf>.

3 *Statement of Chairman Max Baucus*, Trade Bill of 2002. August 1, 2002. <http://finance.senate.gov/press/pr080102.pdf>.

4 Public Law No. 107-210. H.R. 3009, the "Trade Act of 2002." *Conference Report*, H. Rept. 107-624. [http://thomas.loc.gov/cgi-bin/cpquery/R?cp107:FLD010:@1\(hr624\)](http://thomas.loc.gov/cgi-bin/cpquery/R?cp107:FLD010:@1(hr624)):

5 The federal agencies implementing TAA health credits and grants have not yet issued regulations or statutory interpretations. As TAA implementation proceeds, it may grow more or less attractive as a model for future bipartisan progress covering the uninsured. Moreover, if some states fail to participate in the TAA system, enhanced health plan infrastructure may be required to extend TAA-type coverage to additional populations.

6 Katy Saldarini. "Campaign 2000: Bradley plan would share FEHBP with nation." *GovExec.com*. October 12, 1999. <http://govexec.com/dailyfed/1099/101299k1.htm>.

7 Stuart M. Butler and Grace-Marie Arnett. "Solving the Health Insurance Problem for Working Americans." (see also documents cited in footnote 12, page 181). *Priorities for the President* (ed. By Stuart M. Butler and Kim R. Holmes). The Heritage Foundation. 2001. <http://www.heritage.org/Research/Features/Mandate/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=13574>.

8 The descriptions of FEHBP in this section of the paper are generally based on Walton Francis. *Guide to Health Plans for Federal Employees. Washington Consumers' Checkbook*. 23rd Edition, 2001; on OPM, *Federal Employees Health Benefits (FEHB) Program: A Handbook for Enrollees and Employing Offices*. November 20, 2001. <http://www.opm.gov/insure/handbook/fehb00.htm>; and on conversations with Robert E. Moffitt, Walton Francis, and James Morrison.

9 American Postal Workers Union. *APWU Health Plan 2003*. <http://www.apwuhp.com/openseason/71-004.pdf>. Enrollees in this plan receive (a) full coverage of in-network preventive care; (b) Preventive Care Accounts (PCAs) of \$1,000 for self-only and \$2,000 for self and family coverage; and (c) Traditional Health Coverage after PCAs are spent. PCAs may be used to pay for: (i) in-network, medically necessary services covered under the plan; and (ii) "Extra PCA Expenses" – that is, specified dental and vision services, certain preventive services not within the scope of

generally covered benefits under the plan, and any extra charges, beyond Plan allowances, for covered services received from non-network providers. After PCAs are exhausted but before Traditional Coverage begins, enrollees must pay a deductible of \$600 for self-only and \$1,200 for self and family coverage, plus any PCA amounts spent for "Extra PCA Expenses." After such deductibles are met, Traditional Coverage includes 15 percent coinsurance amounts for network care and 40 percent coinsurance for non-network care, plus additional amounts non-network providers charge beyond plan allowances. At the end of the year, unspent PCA funds may be "rolled over" into the following year's PCA, up to a maximum of \$4,000 for self-only and \$6,000 for self and family coverage.

10 5 CFR 890.101, et seq.

11 5 USC 8901, et seq.

12 See <http://www.opm.gov/insure/health/index.htm>.

13 The approach described in the text does not, at least initially, offer "consumer-driven" products to tax credit beneficiaries. 2003 will be the first year in which such plans are part of FEHBP. After some experience accumulates with this quite different type of coverage, a more informed decision can be made about whether and how consumer-driven plans should be included in this program that mainly serves low-income uninsured.

14 This deemed status depends on these programs offering a known level of benefits. Accordingly, Medicaid and SCHIP plans operating under 1115 waivers of benefits or cost-sharing safeguards would not be automatically deemed to qualify.

15 As explained below, the tax credit pays a flat amount, plus a percentage of premiums above that flat amount. As with the FEHBP premium structure, each additional premium dollar is covered by a fixed-percentage subsidy, until the premium hits the cap. Above the cap, workers bear all increased marginal costs.

16 To give workers more powerful incentives to pick the lowest-cost plans, an alternative, reasonable approach would ask workers to pay the full difference between a benchmark premium level on which subsidies are based and the premium for the plan the worker selects. Sara J. Singer, Alan M. Garber, and Alain C. Enthoven. "Near-Universal Coverage Through Health Plan Competition." *Covering America: Real Remedies for the Uninsured*. Economic and Social Research Institute (ESRI). June 2001. <http://www.esresearch.org/RWJ11PDF/singer.pdf>. Such an approach might work well for a national health reform plan, as Singer and colleagues have designed. But under the types of incremental reforms outlined in this paper, in which most recipients of assistance have comparatively low incomes, the approach described in the text has several advantages. First, it is based more closely on an established model (FEHBP) that is generally viewed as successful. Second, as a practical matter, low-income households who do not foresee large, short-term medical bills may have no real choice but to enroll in the lowest-cost plan if they must pay, dollar for dollar, additional premium costs for other plans. The approach in the text tries to avoid the resulting adverse selection and, above all, to offer more realistic choices to low-income families, while still providing significant (albeit reduced) incentives to pick lower-cost plans.

17 Employers could be required to provide such notice as part of job termination and when hiring new employees. In addition, other means-tested public programs could provide notice of health insurance tax credits and an opportunity to apply for coverage. These other programs could do the same for Medicaid and SCHIP as well, providing more "health insurance bang" for the "notice buck."

More broadly, public programs like Medicaid and SCHIP do not currently include any such requirement of prompt enrollment. Policymakers who believe that the lowest-income households are unlikely to wait until they get sick before seeking coverage could limit this prompt enrollment requirement to the moderate-income group of tax credit beneficiaries described below, those employed by small companies.

18 A challenge facing designers of such protections is: (a) limiting plans' exposure to risk sufficiently that they participate at an affordable price; while (b) leaving enough exposure that plans have sufficient incentives to control costs. To address those opposing challenges, reinsurance could cover certain percentages of costs that fall within specified levels. Another possible step to encourage plan participation would permit insurers to earn interest on contingent funding advanced to cover later possible premium costs. Under FEHBP, OPM recovers such interest.

19 Leighton Ku and Teresa A. Coughlin. *The Use of Sliding Scale Premiums in Subsidized Insurance Programs*. Urban Institute. March 1997 (empirical experience with low-income subsidy programs shows take-up rate declines from 57 to 35 to 18 percent of eligible households as workers' premium obligations rise from 1 to 3 to 5 percent of income). <http://www.urban.org/Template.cfm?Section=ByAuthor&NavMenuID=63&template=/TaggedContent/ViewPublication.cfm&PublicationID=6201> For a different perspective, see Mark Pauly, Bradley Herring. "Expanding Coverage Via Tax Credits: Trade-Offs and Outcomes" *Health Affairs*. January/February 2001 (approximately half of uninsured workers with incomes up to 300% of the federal poverty level eventually would take-up tax credits paying 50% of premiums, if over the long run they came to understand the benefits of insurance or the impact of employer-funded health coverage on wages). http://130.94.25.113/1130_abstract_c.php?ID=/usr/local/apache/sites/healthaffairs.org/htdocs/Library/v20n1/s3.pdf

20 Several approaches are possible to determine income. Income could be ascertained based on previous year's tax forms; a recent period of time covered by state earnings records (for example, the two most recently completed calendar quarters preceding application for the credit); by Social Security offices (which determine income levels for the SSI program); or by state SCHIP or Medicaid agencies. For example, the House Medicare prescription drug bill proposed using Medicaid offices to determine low-income seniors' eligibility for special premium and cost-sharing subsidies. H.R. 4954, (Engrossed as Agreed to or Passed by House). SSA Section 1860(g). <http://thomas.loc.gov>. Applicants could also be permitted to ask state agencies to determine their income-eligibility based on applicant statements and matches with existing computerized databases, as discussed below.

21 Several variations of this second eligibility group are listed and briefly analyzed in the tax credit discussion under Category Two.

22 To obtain information about employer-sponsored insurance (ESI), the IRS could add to employers' required information returns questions about health insurance.

23 As calculated based on the full premium, the credit amount would exceed the typical workers' premium share, leaving the family without any health premium costs. If policymakers wish to avoid this result, credits could be set at the level where the remaining family premium share would be the same as if the employer's coverage were purchased through the standard FEHBP look-alike pool; this could be calculated easily by subtracting the employer's payment from the credit amount that ordinarily would apply to the full premium. Alternatively, credits could be capped at a specified percentage of the worker premium payment or a maximum dollar amount. For example, S. 590, cosponsored by Senators Jeffords, Breaux, Frist, Lincoln, Snowe, Chafee, and Carper, would provide credits for individual and family coverage worth \$1,000 and \$2,500, respectively, outside employer coverage but \$400 and \$1,000 if used to purchase ESI. http://thomas.loc.gov/cgi-bin/t2GPO/http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=107_cong_bills&docid=f:s590is.txt.pdf.

24 States facing budget problems could have an incentive to save money by shifting beneficiaries from Medicaid or SCHIP, which states partially fund, into tax credits funded at no state cost. As discussed in the final section of Category Two, below, potential harm could result for vulnerable populations, and federal resources could be diverted away from their intended purpose. One approach to this problem -- a simple bar

on tax credits for individuals eligible for Medicaid and SCHIP – would have serious administrative problems, given the tremendous complexity of those programs’ eligibility requirements. A much more feasible approach would involve “screen and enroll” requirements like those under the SCHIP program. Although such requirements would ensure that applicants for credits receive whatever public coverage is in effect, they would not prevent states from reducing eligibility levels in public programs, in an effort to shift current beneficiaries into a new, federally funded program. To address the latter concern, one approach would simply require states to maintain prior eligibility levels; such a requirement applies to states wishing to receive SCHIP grants. This approach is problematic because, unlike SCHIP, a tax credit does not offer states federal grants in exchange for which they would agree to maintain prior eligibility levels. Alternatively, states that choose to make eligibility cuts could be required to pay their share of the Treasury’s tax credit costs for state residents who would have qualified for Medicaid or SCHIP under previous state law. The Center for Medicare and Medicaid Services could determine each state’s repayment amounts by examining a sample of state residents receiving tax credits, applying standard Medicaid Eligibility Quality Control (MEQC) procedures used to measure Medicaid error rates. See the further discussion of MEQC, below. This second approach has the disadvantage of complexity (albeit based on well-established procedures).

25 Stuart M. Butler of The Heritage Foundation suggested combining fixed and proportional tax credits.

26 The Kaiser Family Foundation and Health Research and Educational Trust. Employer Health Benefits: 2002 Annual Survey. September 2002. <http://www.kff.org/content/2002/3251/>

27 Of course, credit structure is somewhat independent of credit amount. A subsidy like that furnished by the combined credits described in Table 1 could be approximated by fixed credits or proportional credits larger than those in the Table. For example, an FEHBP-type proportional credit covering 75 percent of premium costs would pay \$5,250 for a \$7,000 policy, leaving the family responsible for \$1,750, roughly the corresponding amount in Table 1 for the combination credit. By the same token, a combination credit with a \$1,000 fixed amount plus 50 percent of additional premium costs would cover \$4,000, less than the proportional 65 percent credit in Table 1. By contrast, Figure 1 portrays the feature of combined credits that does not change with credit amounts – namely, as premiums rise, the proportion covered by credits drops more than with proportional credits but less than with fixed credits.

28 The dependent care tax credit exemplifies a phase-down to an amount above zero. That credit declines from 35 percent of qualified expenses to 20 percent as AGI rises from \$15,000 to \$43,000. Frank Sammartino, Eric Toder, Elaine Maag. *Providing Federal Assistance for Low-Income Families through the Tax System: A Primer*. Urban Institute July 2002. <http://www.urban.org/UploadedPDF/410526.pdf>. The advantages of phasing out credits at an amount above zero include: reduced adverse selection, because credits remain non-trivial throughout the income-eligibility range; and smaller increases in effective marginal tax rates as income rises. Disadvantages include greater average federal cost per beneficiary; larger subsidies for higher-income households who have more ability to purchase coverage; and the sudden termination of subsidies at a “cliff” if income rises slightly above eligibility maximums.

29 Straight-line phase-outs to zero were proposed for health insurance tax credits in the House TAA health bill, H.R. 3009, Engrossed Amendment as Agreed to by House, June 26, 2002, <http://thomas.loc.gov/cgi-bin/query/C?c107:/temp/~c107Tt0LGS>; and for premium subsidies in the House Medicare prescription drug bill, H.R. 4954, op cit. Under current law, both the Earned Income Tax Credit and the Dependent Care Tax Credit vary credit amounts based on income, suggesting that the administrative challenges involved in means-tested credit amounts can be overcome.

30 Stuart M. Butler of The Heritage Foundation has suggested this general approach.

31 The adjustment to AGI could be modified to effectuate various credit phase-out schedules. For example, if AGI increased by an amount equal to 125 percent of the credit, the phase-out would steepen and, at the maximum level of income eligibility, arrive at a lower net amount.

32 Strictly speaking, offsets would be based on the marginal tax rate applicable to the increase in AGI. If the credit-based increase caused household income to rise from one tax bracket to another, the marginal rate would straddle the two brackets. For example, in 2001, taxable income was taxed at 15 percent up to \$27,050 for single filers and 27.5 percent above that level. Suppose \$2,000 credits increased AGI from \$26,050 to \$28,050. Half that increase would be taxed at 15 percent and half at 27.5 percent. The net marginal tax rate would be 21.25 percent.

33 An offset-based approach has numerous advantages. As explained below, an effective advance payment mechanism is the linchpin of health insurance tax credits serving low-income households and cannot function effectively if credit amounts are determined by household income. Moreover, an offset-based phase-out offers greater protection of privacy, since credit size does not disclose household income to health plans and others. Administration is simpler for entities that collect and distribute credits, since credit size is determined purely by premium amount and general coverage category (worker-only vs. family coverage). Plans have increased ability to compete based on price, since each plan can clearly state required household premium payments, without any adjustments based on income. By the same token, health plan recruitment is easier since, as far as a plan is concerned, each enrollee in a given coverage category (worker-only coverage, family coverage, etc.) has the same size credit, not a credit amount that varies with household income. IRS administration is likewise simpler, since household income affects the amount of neither the credit nor AGI. Finally, default enrollment strategies are easier to implement, for reasons discussed below.

On the other hand, an offset-based strategy has the disadvantage of varying phase-out rates based on: (a) state of residence, since progressive state income tax brackets create additional offsets as income rises; and (b) household structure, since marginal tax brackets begin at much lower percentages of poverty for households without dependent children. For example, in 2001, a single person without children began owing income tax when income exceeded 96 percent of FPL. Such income tax entry thresholds were, for a married couple without children, 128 percent of FPL; and for families with children, between 201 and 222 percent of FPL. Sammartino, et al., op cit. Another disadvantage is greater complexity in explaining to consumers the operation of these tax credits. Further federal tax adjustments could lessen these inequities between states and households, while worsening the explanatory confusion. See generally Nicholas Johnson. *States Can Avoid Substantial Revenue Loss by Decoupling from New Federal Tax Provision* [sic]. Center on Budget and Policy Priorities. Revised April 30, 2002. <http://www.cbpp.org/3-20-02sfp.htm>

34 This description of TAA advance payment is based on statutory provisions alone. IRS has yet to interpret these provisions, which need not go into effect before August 2003.

35 Sammartino, et al., op cit. Without any requirement to repay advance credits that turn out to be too high, there is a risk that some taxpayers could fraudulently or abusively seek improper or excessive advance payments. That said, the magnitude of this risk may not be enormous. The tax credit beneficiary’s reward from excess advance payments is undeserved health insurance discounts – a significantly lower pay-off than for many other tax fraud schemes.

Nevertheless, it probably makes sense to establish some safeguards to deter, detect, and punish fraud and abuse related to advance payments. Perhaps the most important safeguards are standard IRS enforcement mechanisms, administrative and criminal, that apply to any taxpayer who defrauds the Treasury. Careful policy design of health insurance tax credits can make these mechanisms more effective, of course. As with TAA, state and local agencies issuing advance payment certificates provide some protection; and insurers report advance payments to both IRS and covered workers, which facilitates detection of fraud.

Unlike the tax credit discussed here, the TAA credit is not affected by income. This greatly reduces the potential scope of error and abuse. An offset-based approach to phasing out credits as income rises is needed to capture, at least in part, this feature of TAA credits. With an offset-based phase-out, the size of the credit furnished to the health plan is based entirely on the premium amount and the coverage class (worker-only, family, etc.); income is irrelevant.

Although income does not affect the credit amount, it can deny eligibility for credits if either total earnings exceed maximum income limits or moderate-income workers at small firms are offered employer-sponsored insurance (ESI), in which case eligibility depends on family premium costs above 5 percent of household income. To address the room for error introduced by such income-related eligibility requirements, safeguards not included in TAA legislation could be added. For example, giving agencies that issue advance payment eligibility certificates access to income databases used to administer public benefits programs (described below) could provide an initial check on income-related eligibility for tax credits. At the simplest level, year-end tax forms could also require taxpayers to identify and explain any discrepancies between advance payments for their health insurance and credit amounts as determined at the end of the tax year.

Additional safeguards depend on policymakers' answer to one key policy question: how (if at all) is credit eligibility affected by increased income or other changed circumstances after a household applies for health insurance tax credits? With offset-based phase-outs, such later increases in income would not affect the credit amount. In fact, a household's total income, at year's end, would determine its tax liability, hence the amount of the offset. Rather, changed circumstances could affect only the household's eligibility for credits.

To reduce the uncertainties, administrative complexities, and potential for innocent error if ongoing fluctuations in household income affect credit eligibility, policymakers could base such eligibility on income received during periods before a household applies for credits. For example, a worker could be eligible based on the previous year's income. The Bush Administration's general tax credit proposal for uninsured workers takes this approach. Similarly, eligibility could be based (in whole or in part) on earnings information state workforce departments maintain for recently completed calendar quarters. Under this retrospective approach to determining income-eligibility, credits could be granted for a defined period, such as 12 months or until the end of the year. Along similar lines, most state SCHIP programs now give children 12 months of continuous eligibility, without regard to changed circumstances after their families have applied for benefits (other than failure to pay premiums). Eligibility is then redetermined at the end of each continuous eligibility period, based on household circumstances at the time. Cynthia Pernice, Kirsten Wyses, Trish Riley, and Neva Kaye. *Charting SCHIP: Report of the Second National Survey of the State Children's Health Insurance Program*. National Academy for State Health Policy. July 2001. <http://www.nashp.org/store/prodpage.cfm?CategoryID=3#chip13>.

Rather than take this simpler, retrospective approach, policymakers could vary credit eligibility based on changed circumstances after the initial application. In that case, new hire information reported to state workforce departments could go automatically, along with information about the new employer's health insurance policies, to the agencies issuing advance payment eligibility certificates. This would allow those agencies to redetermine eligibility, given new circumstances when workers change jobs. Workers seeking advance payments could be informed, as happens today with certain public assistance programs, that they are legally obliged to inform such certificate-issuing agencies of changed circumstances that may affect their credit eligibility. Such workers could also be informed whenever the certificate-issuing agency receives information from a new hires database indicating that the worker has begun a new job.

With some combination of these various strategies, as well as the usual IRS criminal and administrative enforcement mechanisms, significant amounts of fraud and abuse seem unlikely to result from limits on reconciliation of excess advance payments.

36 Mills, op cit.

37 Enrollment opportunities could be built into applications for unemployment insurance, with automatic withholding of household premium payments. Other means-tested programs, such as EITC and in-kind benefit programs, could also provide opportunities to apply for credits. At the same time, all of these programs could build in applications for Medicaid and SCHIP, potentially reaching many uninsured children who qualify for coverage under those public programs. See Children's Partnership. *Express Lane Eligibility: Toolkit for Action*. <http://www.childrepartnership.org/expresslane/index.html>.

38 Many of the default enrollment ideas in this paper are taken from Lynn Etheredge's proposals, in which income affects neither the credit amount nor eligibility for credits. *Health Insurance Tax Credits for Workers: An Efficient and Effective Administrative System*. George Washington University Health Insurance Reform Project. September 2001. http://www.kaisernetwork.org/health_cast/uploaded_files/HealthInsuranceAdmin.pdf; and Lynn Etheredge. *How to Administer Health Insurance Tax Credits for Working Families*. Heritage Foundation Background. January 31, 2002. <http://www.heritage.org/Research/HealthCare/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=5316>.

Advance payment mechanisms are more difficult with tax credits that vary based on household income. An offset-based phase-out provides significant advantages in this context, since the credit amount forwarded to the plan is the same for all beneficiaries, regardless of household income. However, as noted above, income is still relevant to determining eligibility, even if the amount of the credit is fixed for all eligibles. To address this problem, default enrollment could be limited to very small companies, most of whose workers are likely to qualify for credits; and to firms not offering insurance. Fully 69 percent of uninsured workers are employed by companies not offering insurance; another 21 percent are ineligible for coverage offered by their employer. Garret, et al., op cit. (Of course, workers would still have the option, outside default enrollment mechanisms, to apply for credits by stating and perhaps documenting that household income is below eligibility maximums and, if relevant, that worker premium costs for available employer coverage would exceed 5 percent of household income.)

Obviously, some workers who do not affirmatively opt out will be ineligible for credits. Accordingly, default applicants will need to be screened for income eligibility. In effect, by not opting out, a worker asks to have his or her eligibility for credits ascertained. To accomplish this, the state and local agencies that issue advance payment eligibility certificates could automatically check databases that include information about income, which is currently made available routinely to Medicaid, food stamp, and TANF agencies. Such databases are operated by, for example, the Social Security Administration, the Department of Labor, the Department of Transportation, state workforce agencies, and the IRS. Laura Cox. *Allowing Families to Self-Report Income: A Promising Strategy for Simplifying Enrollment in Children's Health Coverage Programs*. Center on Budget and Policy Priorities. December 28, 2001. <http://www.cbpp.org/12-28-01health.htm>. U.S. Department of Agriculture. *Summary: Income And Eligibility Verification System (IEVS) Targeting Demonstration*. December 22, 1994, updated March 7, 2002. <http://www.fns.usda.gov/oane/MENU/Published/FSP/FILES/Program%20Integrity/IEVSSummary.htm>. In addition, W-4 forms could be expanded for workers to identify spouses and dependent children, thereby permitting some automated determination, based on IRS data, of total household income as a percentage of federal poverty levels. As information from any of these databases can err or be outdated, households need to be given notice and an opportunity to contest eligibility denials based on database information. And of course, households applying outside default enrollment mechanisms would have other opportunities to claim and perhaps document limited income, as discussed above. In addition, workers receiving other means-tested public benefits, such as food stamps or, for employees of small companies, EITC, could automatically be deemed income-eligible for health insurance tax credits. Under this set of approaches, workers who do not opt out and are found income-eligible based on these automated procedures would receive, not just credits, but also advance payments.

More broadly, policymakers could consider the further default enrollment option of transferable tax credits, perhaps as a pilot project in certain states. Under this approach, if the worker opts out, the federal government transfers the tax credit to the worker's state, which provides the worker with basic health insurance fully funded by the credit, without any required worker contribution. Such basic insurance would be required to meet minimal standards, such as an actuarial value roughly comparable to Medicare (perhaps with prescription drug coverage added). Lynn Etheredge. *Tax Credits for Uninsured Workers*. Health Insurance Reform Project, George Washington University. September 1999. <http://www.gwu.edu/~Ehirp/publications/taxcredit.pdf>.

39 Ku, et al., op cit. Along similar lines, an empirical study of employer coverage concluded that "low-earning workers will not take up benefits when they face large monthly premium contributions. Hence, to ensure widespread participation among such workers, employers must make certain that at least one plan requires little or no employee contribution." This conclusion was based on findings that, in low-wage firms (that is, those with workers 35 percent or more of whom earned under \$20,000 a year), when worker premium costs rose from \$0 to \$50 a month, total take-up among all workers fell from 89 percent to 72 percent. In high-wage firms (that is, where 10 percent or less of the workforce earned below \$20,000 a year), take-up fell much more modestly, from 89 to 84 percent. When premium costs rose to \$100 a month, take up rates among low-wage and high-wage companies, respectively, fell to 55 and 79 percent. Jon R. Gabel, Jeremy D. Pickering, Heidi H. Whitmore, and Cathy Schoen. "Embraceable You: How Employers Influence Health Plan Enrollment." *Health Affairs*. July/August 2001. Vol. 20, number 4. <http://130.94.25.113/readeragent.php?ID=/usr/local/apache/sites/healthaffairs.org/htdocs/Library/v20n4/s22.pdf>. For a different perspective, see Pauly, et al., op cit.

40 An alternative approach would give states resources with which they could supplement credits. This approach appeals to policymakers who prefer state to federal implementation of coverage expansions. However, policymakers wishing to avoid the resulting administrative complexity or to ensure affordable access to comprehensive coverage in all states may prefer to adjust the credit amount at the federal level.

41 The Kaiser Family Foundation and Health Research and Educational Trust. Op cit.

42 2003 FEHB premiums, non-postal rates (2002 rate information). Calculations by ESRI, October 2002. <http://www.opm.gov/insure/health/03rates/http://www.opm.gov/insure/health/03rates/>

43 OPM. *THE FACT BOOK: 2001 Edition. Federal Civilian Workforce Statistics*. July 2001. <http://www.opm.gov/feddata/01factbk.pdf>.

44 James J. Choi, David Laibson, Brigitte Madrian, Andrew Metrick. *For Better or For Worse: Default Effects and 401(K) Savings Behavior*. National Bureau of Economic Research Working Paper 8651. December 2001. <http://papers.nber.org/papers/w8651>. Calculations by ESRI, June 2002.

45 For example, plans offering limited coverage in New Jersey have been used by no more than 4.2 percent of all individual purchasers in the nongroup market and only 0.03 percent of small employers. New Jersey Department of Health and Senior Services. *Report of the Task Force on Affordability and Accessibility of Health Care in New Jersey*. January 2001. <http://www.state.nj.us/health/commiss/aatf.pdf>.

46 See Butler, op cit. This approach would have the advantages of leveraging finite federal resources to provide greater assistance to low-income households; providing a manageable vehicle for employers to contribute to low-wage workers' health coverage; and furnishing a new opportunity for voluntary, charitable behavior. These advantages could be particularly pronounced if, for credits to be available in a particular state, the state government somehow had to require or encourage public or private matching funds. On the other hand, this approach could make credits' ability to help low-income households depend on matching payments that may not be forthcoming from many states and employers. Moreover, permitting states to supplement credits could provide an easy mechanism for states to encourage the wholesale shift of beneficiaries from Medicaid and SCHIP into tax credits, discussed above.

47 Garret, et al., op cit. Calculations by ESRI, June 2002.

48 This occurs because 58 percent of workers in the relevant group (firms under 10 workers, income under 200 percent of FPL) are uninsured. If 72 percent of them take up subsidies, then 42 percent of workers in the relevant group will (a) previously have been uninsured and (b) receive subsidies. Already, 42 percent of workers in the relevant group are insured and presumably would accept subsidies to lower their net coverage costs.

49 Mills, op cit.

50 Pernice, et al., op cit.

51 This approach would have the advantage of covering needy, uninsured workers otherwise denied credits. Its disadvantages include administrative challenges involved with short-term ineligibility for employer coverage and opportunities for employers to "game" the system by placing otherwise insured low-income workers into job categories ineligible for ESI, such as part-time work.

52 Agency for Healthcare Research and Quality, Center for Cost and Financing Studies. *1999 Medical Expenditure Panel Survey - Insurance Component*. <http://www.meps.ahrq.gov/MEPSDATA/ic/1999/Index199.htm>. Calculations by ESRI, June 2002.

53 Some may be concerned about the work disincentive that results from increased marginal tax rates when net credit amounts drop as earnings rise. However, any subsidy approach that decreases or eliminates subsidies based on increased income will create work disincentives. For example, public program eligibility typically ends at an absolute upper income threshold. In effect, subsidies drop from something like 100 percent of premiums to zero as family income rises from slightly below to slightly above the eligibility limit. This gives workers an incentive to keep earnings below maximum eligibility levels.

54 Robert E. Moffit. *Recent Premium Increases and the Future of the FEHBP*. Testimony before the House Subcommittee on Civil Service and Agency Organizations. October 16, 2001. <http://www.heritage.org/Research/HealthCare/Test101601.cfm>.

55 Three technical comments are needed at this point. First, while "need-based Medicaid" would not incorporate categorical eligibility requirements pertaining to age, disability, parenting, and pregnancy, it would leave intact non-categorical eligibility requirements like state residence and satisfactory immigration status. Jane Perkins and Sarah Somers. *An Advocate's Guide to the Medicaid Program*. National Health Law Program. June 2001. <http://www.healthlaw.org/advguide/index.shtml>. Second, policymakers may need to consider the income methodologies available to states. Permitting states to use existing methodologies for new eligibility categories seems administratively advantageous; the Medicaid statute already does this with optional eligibility categories, basing income methodologies on the most closely related cash assistance group. 42 U.S.C. 1396a(a)(17), (a)(17)(B), (I)(3). With such an approach, policymakers first identify the most closely related current eligibility group and then apply its income methodology to the new group. In this case, the most closely related group is clearly low-income parents covered under Section 1931(b) of the Social Security Act (SSA). Such parents and beneficiaries of expanded coverage will be the only Medicaid categories comprised of working-age adults whose eligibility is not based on severe disability or pregnancy. For such parents, states may use any methodology to evaluate income that is not more restrictive than the methods the state formerly used for cash assistance before adoption of the Personal Responsibility and Work Opportunity Act (PRWOA). Presumably, that same flexibility would apply to the new eligibility group discussed here. Third, policymakers could consider whether to give states the discretion to limit eligibility to individuals with assets (for example, automobiles, savings accounts, rental property, etc.) valued below a certain level. Although most states apply assets tests to parents, they have been largely

abolished for children, thereby eliminating significant procedural burdens on states and beneficiaries. Donna Cohen Ross and Laura Cox, Center on Budget and Policy Priorities. *Enrolling Children and Families in Health Coverage: The Promise of Doing More*. Kaiser Commission on Medicaid and the Uninsured. June 2002. <http://www.cbpp.org/6-30-02health.pdf>. The vast majority of low-income people have very limited assets other than homes, which Medicaid disregards in determining eligibility. Stacey Carney and William G. Gale. *Asset Accumulation Among Low-Income Households*. NBER and Brookings Institute, February 2000 Revision (and studies cited at pp. 2-4). <http://www.brook.edu/dybdocroot/views/papers/gale/19991130.pdf>. Some state officials may seek the option to impose asset tests, however, for several reasons: a principled commitment to state flexibility whenever possible; concern that dispensing with assets tests for this new group could be unfair to other Medicaid adults, for whom most states impose asset tests; fear of public embarrassment if a state's Medicaid program is found to cover even one person with substantial assets like expensive cars and large bank accounts; and a desire to retain the flexibility to limit enrollment by making application procedures sufficiently difficult and complex that many cannot complete the process.

56 Some may fear that need-based Medicaid could make it easier for states to eliminate coverage for Medicaid beneficiaries at higher income levels. If that occurs, this new category of optional Medicaid eligibility could ultimately increase, rather than reduce, the number of uninsured. To avoid this result, federal policymakers could require that a state choosing to implement need-based Medicaid must retain previous Medicaid and SCHIP coverage. SCHIP legislation contained a similar requirement that, for a state to receive SCHIP funding, it must keep intact previous Medicaid coverage for children. Similarly, states wishing to implement optional Medicaid coverage for pregnant women have long been required to retain the previous coverage they offered such women. Of course, these "no eligibility cutbacks" rules for exercising new Medicaid options have disadvantages: some view them as excessive federal intrusion into state affairs; states wishing to retain the flexibility to cut other Medicaid eligibility categories could be deterred from implementing need-based Medicaid; the states that went farthest beyond federal, minimum requirements would be affected the most by such rules, raising equity concerns; and states could be discouraged from future, optional expansions, fearing that exercised options can later become mandates.

57 With other populations covered by public programs, such as parents covered by SSA Section 1931(b) and children covered by SSA Section 1902(r)(2), such limits have been effectively overridden by states' flexibility to determine methodologies for evaluating income, as described in the second technical comment above. Perkins and Somers, op cit.

58 The following states have received demonstration project waivers under Section 1115 of the Social Security Act to cover childless adults: Arizona, Delaware, the District of Columbia, Hawaii, Illinois (for a limited population), Maine, Massachusetts, Minnesota, New Mexico, New York, Oregon, Tennessee, Utah (very limited benefits), and Vermont. Cindy Mann. *The New Medicaid and CHIP Waiver Initiatives*. Kaiser Commission on Medicaid and the Uninsured. February 2002. <http://www.kff.org/content/2002/4028/4028.pdf>. U.S. Department of Health and Human Services, HHS Approves New Mexico Request to Expand Health Insurance Coverage to 40,000 People. August 23, 2002. <http://www.hhs.gov/news/press/2002pres/20020823a.html>. Donna Schmidt. HIFA -- Health Insurance Flexibility and Accountability. Centers for Medicare and Medicaid Services (CMS). September 23, 2002 presentation to HRSA SPG grantees, Washington, D.C. *Terms and Conditions, Illinois KidCare Parent Coverage Demonstration*. CMS (undated). <http://www.cms.gov/hifa/ilkidcaretc.pdf>. In 2001, CMS simplified the process of seeking waivers, establishing a template letting states expand coverage to new groups while achieving federal cost-neutrality in specified ways by cutting back services or increasing costs for current beneficiaries. This is known as the "Health Insurance Flexibility and Accountability" (HIFA) initiative. CMS. *Health Insurance Flexibility and Accountability (HIFA) Demonstration Initiative*. Last modified June 20, 2002. <http://www.cms.gov/hifa/default.asp>.

59 Senator Orrin Hatch. *New Data: Nearly 5 Million Children in America are Needlessly Uninsured*. Secretary Thompson Helps Kick Off Enrollment Drive and Senators Hatch and Kennedy Honored on 5th Anniversary of SCHIP. Robert Wood Johnson Foundation Media Release. August 1, 2002. <http://www.rwjf.org/newsEvents/mediaRelease.jsp?id=1027535543103>

60 Catherine Hoffman and Mary Beth Pohl. *Health Insurance Coverage in America: 2000 Data Update*. Kaiser Commission on Medicaid and the Uninsured. February 2002. <http://www.kff.org/content/2002/4007/4007.pdf>. Calculations by ESRI, June 2002.

61 Medicaid eligibility was originally linked to two cash assistance programs: Supplemental Security Income (SSI) for low-income elderly, blind, and disabled; and Aid to Families with Dependent Children (AFDC) for certain parents and children. Over time, Medicaid eligibility expanded incrementally to cover ever-increasing numbers of seniors, people with disabilities, children, pregnant women, and parents not receiving cash assistance. However, the one household type not served by these two cash assistance programs -- namely, adults who are neither pregnant, parenting, elderly, nor severely disabled -- has remained outside Medicaid's optional coverage groups, for no apparent reason other than its original exclusion from SSI and AFDC as Medicaid began.

62 Of course, as noted above, non-categorical requirements, like state residence, would remain. Perkins and Somers, op cit.

63 Several states (Arizona, California, Illinois, Minnesota, New Jersey, New Mexico, Rhode Island, Wisconsin) have obtained waivers to cover parents under SCHIP, financed by unused SCHIP grant funds that the states otherwise would forfeit, "drawn down" at SCHIP matching rates. Some of these waivers either allowed unspent SCHIP grant funds to substitute for state and federal Medicaid dollars (Minnesota, Rhode Island, Minnesota, Illinois) or remain unimplemented (e.g., California). Cindy Mann, op cit. Donna Schmidt, op cit.

64 Jocelyn Guyer. *Low-Income Parents' Access to Medicaid Five Years After Welfare Reform*. Kaiser Commission on Medicaid and the Uninsured. June 2002. <http://www.kff.org/content/2002/4052/4052.pdf>.

65 Cindy Mann, David Rousseau, Rachel Garfield, Molly O'Malley. *Reaching Uninsured Children through Medicaid: If You Build It Right, They Will Come*. Kaiser Commission on Medicaid and the Uninsured. June 2002 (sources cited at footnote 6, page 5). <http://www.kff.org/content/2002/4040/4040.pdf>. Enrolling eligible children is an important issue; 58 percent of all uninsured children now qualify for Medicaid or SCHIP but are not enrolled. Lisa Dubay, Ian Hill, and Genevieve Kenney. *Five Things Everyone Should Know about SCHIP* (note 14). The Urban Institute. October 2002. http://www.urban.org/UploadedPDF/310570_A55.pdf.

66 This new federal option would not eliminate states' ability to continue seeking and implementing HIFA and other 1115 waivers to cover childless adults. If anything, budget neutrality required to obtain such waivers could be easier to show. Under approaches HCFA applied during the previous Administration, a state could include, in its baseline projection of federal spending without the waiver, the costs of expanded coverage through state plan amendments that the state had not yet proposed or implemented. *Medicaid: Spending Pressures Drive States Toward Program Reinvention*. GAO/HEHS-95-122. General Accounting Office. April 1995. <http://www.gao.gov/>. Under this approach, greater latitude for optional coverage translates into a higher potential baseline, making cost-neutrality easier to achieve.

67 Employers cover 18.1 percent of workers with incomes under 100 percent FPL; 37.9 percent of workers with incomes between 100-149 percent FPL; 53.8 percent between 150-199 percent FPL; 69.7 percent between 200-299 percent FPL; and 86.6 percent at 300 percent FPL and above. Hoffman and Pohl, op. cit.

68 Christine Ferguson, Patricia Riley, and Sara Rosenbaum. *Medicaid: What Any Serious Health Reform Proposal Needs To Consider*. ESRI 2002 (Publication expected November 2002). Despite low-income households' unique inability to pay for uncovered services, some policymakers oppose providing them coverage more generous than typical employer insurance furnished to workers who may have some ability to supplement cov-

ered benefits. Charles Milligan. *North Carolina Medicaid Benefits Study*. The Lewin Group. May 2001. http://www.quintiles.com/products_and_services/specialty_consulting/the_lewin_group/lewin_publications/detail/1,1278,171,00.html.

69 Some may claim that it would be complex and arbitrary to provide this new eligibility group with increased federal match. However, if federal matching percentages for need-based Medicaid were enhanced to encourage state implementation, that would not be the first time Medicaid has varied match rates among program components to achieve national policy goals. In addition to SCHIP match rates received by states implementing SCHIP through Medicaid expansions, special Medicaid matching percentages have applied to, for example, family planning services and computerized information management systems (automatic 90 percent match for both categories), medically skilled administrative staff costs (75 percent), general administrative costs (50 percent match, regardless of the state's usual match rate), etc. Moreover, unlike SCHIP, which raised federal match for higher-income children alone, this approach provides higher match to the lowest-income state residents ineligible for prior coverage. This reduces but does not entirely eliminate arbitrariness, as some beneficiaries in older coverage categories would have lower incomes than some beneficiaries in the new group receiving enhanced match.

70 The purpose of denying enhanced match to beneficiaries eligible under prior law is to ensure that new federal dollars give states incentives to expand coverage, not just to shift already covered beneficiaries from old into new eligibility categories. Under the approach described in the text, to determine the proportion of need-based beneficiaries who are ineligible under prior eligibility categories and who therefore qualify for enhanced match, CMS could review a small but representative sample of case files. For decades, CMS (in its prior incarnation as the Health Care Financing Administration, or HCFA) has used this procedure as the standard Medicaid Eligibility Quality Control (MEQC) method for determining state error rates for Medicaid eligibility determinations. Such retrospective sampling is needed for this approach to offer administrative savings and simplicity. Otherwise, states would be required to gather and process information from all applicants showing whether they would have qualified for other categories of Medicaid eligibility. Note: CMS has encouraged states to use MEQC targeted case file reviews innovatively to achieve such goals as evaluating the impact of procedural simplifications. *State Medicaid Director Letter re MEQC and Other Monitoring Activities*. HCFA September 12, 2000 (revised by CMS effective April 26, 2002). <http://www.cms.hhs.gov/states/letters/smd91200.asp>.

71 Since the adoption of SCHIP, the number of states covering uninsured children up to 200 percent of FPL rose from 6 to 40. Ross and Cox, op cit.; Health Policy Studies Division, NGA Center for Best Practices. *MCH Update: State Medicaid Coverage of Pregnant Women and Children*. September 30, 1997. <http://www.nga.org/cda/files/MCHUPDATE0997.pdf>. Even the states capping eligibility at income levels below 200 percent of FPL all responded to SCHIP by expanding coverage for some previously uninsured children. Ross and Cox, op cit. Unfortunately, no matter how need-based Medicaid is structured, it cannot duplicate all the elements that contributed to SCHIP's universal implementation. Many states created non-Medicaid SCHIP programs, which is not an option under the approach described here. Many state budgets had large surpluses during SCHIP implementation; such a rosy fiscal climate may not return soon. And of course, adults lack some of children's political appeal.

72 This basic approach was suggested in John F. Holahan, Len M. Nichols, and Linda J. Blumberg. "Expanding Health Insurance Coverage: A New Federal / State Approach." Published in Economic and Social Research Institute. *Covering America: Real Remedies for the Uninsured*. June 2001. <http://www.esresearch.org/RWJ11PDF/holahan.pdf>. Enhancing match rates both for previous and expanded Medicaid coverage also makes it more palatable for policymakers, as discussed above, to require states implementing this new optional eligibility to retain previous Medicaid eligibility, since such previous categories would receive enhanced match. This approach would also avoid the inequities, problematic incentives, and complexity of providing higher federal match for new than for older coverage groups. It could be taken even farther by equalizing match rates for Medicaid and SCHIP at some intermediate level.

73 If enhanced match is limited to recipients of need-based Medicaid, states can seek additional federal dollars without expanding coverage by shifting already enrolled, low-income parents into the new eligibility category. Along similar lines, if enhanced match is provided for all Medicaid beneficiaries, regardless of category, states can expand coverage on paper while discouraging new enrollment and resulting costs by failing to conduct significant outreach and permitting procedural obstacles (such as long and burdensome forms, frequent certifications required for continued eligibility, and extensive documentation requirements) to limit the number of newly eligible people who actually receive and retain expanded coverage. To prevent such results, federal policymakers pursuing the first option in the text would need to apply the MEQC procedures described above. Those using the second approach could limit enhanced match to states that apply to their need-based Medicaid: (a) all simplification and streamlining procedures that the majority of states employ for children; (b) outreach no less extensive than what the state itself used during SCHIP implementation.

74 Thomas Scully, Administrator, Centers for Medicare & Medicaid Services. *National Association of State Medicaid Directors Annual Meeting*. October 8, 2002. http://www.kaisernetwork.org/health_cast/uploaded_files/kff_100802_nasmd.pdf.

75 State policy choices have played an important role in some states' failure to spend their SCHIP grants. A number of states have been slow to expand children's coverage, to implement procedural improvements, or to conduct effective outreach. Margo Edmunds, Martha Teitelbaum, and Cassy Gleason. *All Over the Map: A Progress Report on the State Children's Health Insurance Program (CHIP)*. Children's Defense Fund. July 2000. http://www.childrensdefense.org/pdf/cdfchip_report.pdf. Nevertheless, some important factors that affect SCHIP spending are outside the control of state policy. For example, states like California and Texas have large numbers of immigrant families with uninsured children who, based on understandable fears about immigration status and sponsor deeming, are reluctant to apply for coverage; states like Minnesota and New Mexico had generous prior Medicaid coverage of children up to comparatively high income levels, limiting the range of children on whom SCHIP funds can be spent; the SCHIP statute permits New York, Pennsylvania, and Florida to substitute SCHIP grants for prior state spending on non-Medicaid health coverage programs for children; and SCHIP funding is based on estimates of uninsured children in each state derived from multi-year averages of the Census Bureau's March Current Population Survey (March CPS). The March CPS has small samples in some states that can create significant variance from true levels of uninsurance. Moreover, multi-year averages necessarily fail to capture the full extent of rapid changes in coverage levels, such as those apparently happening now. In an ideal world, one can imagine state allotment criteria without significant mismatches between grant levels and state needs. But in reality, lawmakers must make policy decisions against the constraints of limited information, difficult policy trade-offs, fiscal limitations, and political factors. Accordingly, mismatches may be inevitable with any federal formula to determine state grant amounts, whether for children or other uninsured Americans. Moreover, policymakers seeking to allot state-specific amounts of enhanced funds may stir up "formula fights" among states, which complicate passage. One approach to limiting such mismatches (and perhaps narrowing the scope of formula fights) is embodied in S. 2860, which establishes a special caseload stabilization fund to redistribute unspent allocations to the states that have overspent their allotments. http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=107_cong_bills&docid=f:s2860is.txt.pdf.

76 This policy has additional advantages and disadvantages. Capping the total amount of enhanced federal matching funds limits federal budget risks. On the other hand, capping state allotments reduces the automatic responsiveness of federal funding to caseload changes, responsiveness that yields fiscal benefits to state government during recession while helping stabilize the economy through countercyclical spending. Also, if allotments are small, the financial appeal of enhanced federal funding will be limited and may not catalyze widespread state implementation.

77 Another precedent is the \$500 million in federal funding for enhanced match targeted to TANF/Medicaid outreach and related activities. These funds help states adjust their Medicaid programs to PRWOA and effectively provide delinked Medicaid to families eligible under SSA

Section 1931(b). Each state has an allotted share of the \$500 million. Once that money is gone, a state reverts to standard Medicaid match rates for administrative expenses. Indeed, states are permitted to reclassify former administrative expenses to qualify for enhanced match using this \$500 million fund. *State Medicaid Director Letter re: Claiming Reimbursement Under the \$500 Million Fund for TANF/Medicaid Outreach*. HCFA. January 6, 2000. Modified by CMS effective April 26, 2002. <http://www.cms.gov/states/letters/wrd11600.asp>.

78 Of course, state implementation and spending can start slow and later grow, as happened with SCHIP. SCHIP addressed this pattern by permitting states to “roll-over” unused funds for three years, after which unspent funds were to be forfeited to other states and then, if still unspent after a year, to the Treasury. To avoid the many challenges of multi-year roll-overs under SCHIP, policymakers could take a slightly different approach with need-based Medicaid, starting state allotments small and having them rise, after two or three years, to a level that remains constant, year after year. Under this modified approach, unspent allocations could go immediately, at the end of each year, into a fund reserved for distribution to other states.

79 For a discussion of how state Medicaid programs have maximized their receipt of federal revenue using innovative strategies, see Teresa A. Coughlin and Stephen Zuckerman. *States’ Use of Medicaid Maximization Strategies to Tap Federal Revenues: Program Implications and Consequences*. Urban Institute. June 2002. http://www.urban.org/UploadedPDF/310525_DP0209.pdf. On the other hand, permitting some substitution of federal for state dollars to offset expansion costs may help persuade a number of states to implement this expansion. Also, without some such substitution, the states that previously used their own funds, without federal match, to cover childless adults and low-income parents would be the most limited in their ability to spend federal funds. This raises equity issues like those discussed below. Policymakers could try to prevent such substitution with maintenance-of-effort requirements, but it may not be easy to devise such requirements that apply effectively to such a broad range of state spending outside the confines of the Medicaid program.

80 Mann, Rousseau, et al., op cit.

81 Cohen Ross and Cox, op cit.

82 Victoria Wachino. *State Budgets Under Stress: How are States Planning to Reduce The Growth in Medicaid Costs?* Kaiser Commission on Medicaid and the Uninsured. July 30, 2002. <http://www.kff.org/content/2002/20020730/statbudupdate73002.pdf>.

83 Neva Kaye. *Medicaid Managed Care: A Guide for States (Fifth Edition)*. National Academy for State Health Policy. May 2001. Pam Silberman, Stephanie Poley, Kerry James, and Rebecca Slifkin. “Tracking Medicaid Managed Care In Rural Communities: A Fifty-State Follow-Up.” *Health Affairs*. July/August 2002. <http://130.94.25.113/readeragent.php?ID=/usr/local/apache/sites/healthaffairs.org/htdocs/Library/v21n4/s34.pdf>. Robert Hurly and Michael McCue. *Partnership Pays: Making Medicaid Managed Care Work in a Turbulent Environment*. Center for Health Care Strategies. May 2000. <http://www.chcs.org/publications/pdf/ips/Hurley.pdf>. Holahan and Weiner, op cit.

84 If policymakers take this modified approach, they could give states additional flexibility to vary the ages of coverage for childless adults. For example, while the District of Columbia hopes ultimately to cover all low-income childless adults via an 1115 waiver, it has begun such coverage with adults aged 50 to 64. States today have similar discretion with so-called “medically needy” children under age 21. States may limit coverage to children under age 20, for example, or cover “reasonable classifications” of children under age 21, such as children in foster care. Perkins and Somers, op cit.

85 Under an approach targeted expressly to childless adults, a state could “game the system” by enrolling (or shifting) into this new category disabled, childless adults who also qualify under previously enacted disability-based coverage. Such reclassification would bring in new federal funds without expanding coverage. It could help some beneficiaries and harm others. Applicants with very low income would be enrolled more quickly without the often time-consuming need for obtaining determinations of disability. Many with somewhat higher earned income, however, would lose coverage if their eligibility were analyzed in terms of need-based rather than disability-based Medicaid, since the latter uses unusually generous methodologies for evaluating earned income, with substantial disregards. Fortunately, standard MEQC methods described above could address this risk. Under this approach, federal authorities would evaluate disability of a sample of childless adults in each state and eliminate enhanced match for all the state’s childless adults based on the proportion who, according to the sample, also would have qualified as disabled under prior state law.

86 Some may feel that an expansion expressly tailored to help childless adults could be more difficult politically, despite net state and federal costs lower than for need-based Medicaid, which in most states will also include parents previously ineligible for Medicaid.

87 Such state flexibility to cover recent immigrants was included in legislation approved by the Senate Finance Committee to reauthorize the Temporary Assistance for Needy Families (TANF) program. H.R. 4737, approved in Committee on June 26, 2002. <http://thomas.loc.gov/cgi-bin/query/D?c107:4.:/temp/~c107qF8RX6:e358718>.

88 A bipartisan group of 15 Senators has proposed such an expansion in S. 1244. <http://thomas.loc.gov/cgi-bin/query/C?c107:./temp/~c107Az9mYB>.

89 S. 321 proposes such an expansion.

90 Stuart M. Butler. *Time for Bipartisan Action to Help Families Without Health Insurance*. Heritage Foundation Background. March 20, 2002. <http://www.heritage.org/Research/HealthCare/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=6333>.

91 For example, states could provide access to plans that already serve beneficiaries of Medicaid, SCHIP, state public employee programs, or high-risk pools. The Bush Administration’s tax credit proposal included a similar feature. One potential problem to guard against would be adding disproportionately high-risk enrollees to existing public programs without adequate premium payments.

92 For such nationwide plans to function smoothly across state lines, they may need to be exempt from state insurance regulation. A similar exemption applies under current law to nationwide plans participating in the Federal Employees Health Benefits Program (FEHBP).

93 Garret, Nichols, et al., op cit. Calculations by ESRI, June 2002.

94 Another default mechanism could perhaps keep premiums for national fallback plans below the cap without any federal spending on financial incentives such as reinsurance, stop-loss provisions, or risk adjustments. Under this default enrollment mechanism, a tax credit beneficiary not affirmatively selecting a particular plan could be assigned randomly to a fallback plan, perhaps with higher market share awarded to such plans with better quality indicators. As procedural safeguards, enrollees would need to receive clear and prominent advance notice of default enrollment procedures and also have a certain period of time (for example, 30 days after first receiving notice of coverage) in which to disavow the enrollment or change plans. The potential power of such default enrollment mechanisms was illustrated by the above-described study of 401(k) pension plans, which found that 77 percent of all employees chose investment vehicles by default during their first year. Choi, et al., op cit. A different approach to default enrollment, used by the so-called Tripartisan proposal for Medicare drug coverage (S.B. 2, introduced July 15, 2002), would place individuals not choosing a health plan into the least expensive available plan. The advantages of this alternative are that workers are not subjected to extra costs by default; and federal funds are conserved if partially proportional credits apply to smaller premiums.

The disadvantages are that consumers, based on past experience, prefer more comprehensive coverage; and, perhaps more important in the context of this particular approach, the fall-back pool would lose low-cost, default enrollees, and federal expenditures for financial incentives would increase.

Another policy to reduce adverse selection would permit fall-back plans to raise premiums when workers shift from less-generous coverage (for example, in the nongroup market) previously purchased with the help of credits. Such a policy would discourage healthy workers from enrolling in the least expensive possible coverage with the intent of shifting to more comprehensive, back-up plans if they get sick. To deter such gaming of the system, and to ensure that plans can raise premiums enough to cover their costs, state insurance regulations limiting risk-based premium variation might need to be preempted when tax credit beneficiaries shift from less generous coverage into fall-back plans.

95 The approach described in the text also addresses several additional concerns about tax credits:

“When health insurance tax credits were briefly available during the early 1990s, many low-income families were victimized by marketing fraud.” House Ways and Means Committee. Subcommittee on Oversight. *Report on Marketing Abuse and Administrative Problems Involving the Health Insurance Component of the Earned Income Tax Credit*. WMCP: 103-14, 103rd Cong., 1st Sess., June 1, 1993. The suggested approach addresses this danger in two ways. First, enrollment takes place at the workplace, reducing (though not eliminating) unsupervised marketing. Second, tax credits include funding for consumer assistance and advice, rendered without financial incentives to steer consumers to any particular plan. If such measures are feared to be inadequate, safeguards in the Medicaid statute could be applied to this program. Such safeguards, for example, forbid “cold calling;” require enrollment through neutral brokers; and provide independent, state review of insurers’ marketing materials. 42 U.S.C. Section 1396u-2(d)(2); Health Care Financing Administration (HCFA), *Dear State Medicaid Director Letter* (December 30, 1997). <http://www.cms.hhs.gov/states/letters/bbamisc.asp>.

“Significant market reforms are needed if health insurance tax credits can be used in the nongroup market.” Such reforms could be added to the tax credit approach described in the text. For a general discussion of this issue, see Beth Fuchs, Mark Merlis, and Julie James. *Expanding Health Coverage for the Uninsured: Fundamentals of the Tax Credit Option*. National Health Policy Forum Background Paper. August 28, 2002. [http://www.nhpf.org/bkgd/1-121+\(TaxCredits_8-02\).pdf](http://www.nhpf.org/bkgd/1-121+(TaxCredits_8-02).pdf). For one recently proposed, innovative approach, see Vic Patel and Mark Pauly. “Guaranteed renewability and the problem of risk variation in individual health insurance markets: A way to stabilize coverage with less government interference.” *Health Affairs*. August 28, 2002 Web Exclusive. http://www.healthaffairs.org/WebExclusives/Pauly_Web_Excl_082802.htm. However, the tax credit approach described in the text tries to avoid potentially contentious questions of insurance regulation by providing affordable access to relatively comprehensive, group coverage as a practical alternative for consumers who wish to avoid the nongroup market.

96 Sharon Silow-Carroll, Todd Kutyla, Jack A. Meyer. *The State of Employment-Based Health Coverage and Business Attitudes About Its Future*. ESRI (published by The Commonwealth Fund). April 2001. <http://www.esresearch.org/Documents/Busattitudes2001.pdf>.

97 Etheredge, 2002, op cit.

98 In the early 1990s, the so-called “Bentsen child health tax credits” provided limited assistance to a small number of families. The program was repealed after one year of operation, in part due to administrative problems and marketing fraud. Beth Fuchs, Jeane Hearne, Bob Lyke, and Patrick Purcell. *Health Insurance for Children: Legislation in the 105th Congress*. Congressional Research Service. Updated August 1, 1997. As noted in the introduction, the recent trade bill included the country’s second attempt ever to use tax credits to expand health coverage to the uninsured. The new credits first become effective December 1, 2002.

99 Jack A. Meyer and Elliot K. Wicks, “A Federal Tax Credit to Encourage Employers to Offer Health Coverage, *Inquiry*, Vol. 38. No. 2, Summer 2001. Judith Feder, Larry Levitt, Ellen O’Brien, Diane Rowland. “Assessing the Combination of Public Programs and Tax Credits;” *Covering America: Real Remedies for the Uninsured*. ESRI. June 2001. <http://www.esresearch.org/RWJ11PDF/feder.pdf>; <http://www.esresearch.org/RWJ11PDF/wicks.pdf>.

Families USA, the Health Insurance Association of America, the American Hospital Association, and other groups have suggested, as part of a larger hybrid proposal, an interesting variant on employer tax credits that would fund employers’ enhanced premium payments that are specifically targeted to low-income workers. See Families USA. “*Strange Bedfellows*” *Join Forces On Agreement For Uninsured Americans*. November 20, 2000. <http://www.familiesusa.org/media/press/2000/prstrnge.htm>. In 1999, fewer than 1 percent of all employees worked for companies offering extra payments for their low-income workers’ premiums or deductibles. Gabel and Pickering, op cit.

Another option for employer credits would subsidize both employer and employee premium shares. As noted below, a similar policy in Massachusetts apparently stopped erosion of employer coverage and actually increased employers’ provision of health insurance.

100 One survey found that, among employers with fewer than 13 full-time workers, the majority opposed employer responsibility for managing health coverage. Such management responsibilities included selecting a benefit package, negotiating with insurers, etc. Silow-Carroll, Kutyla, et al., 2001, op cit.

101 Sharon Silow-Carroll, Stephanie E. Anthony, and Jack A. Meyer. *State And Local Initiatives To Enhance Health Coverage For The Working Uninsured*. ESRI (published by The Commonwealth Fund). November 2000. http://www.cmf.org/programs/insurance/silow-carroll_initiatives_424.pdf.

102 1.8 million workers were employed at companies meeting both criteria – that is, they had fewer than 10 workers, at least half of whom worked in low-wage jobs. Agency for Healthcare Research and Quality, op cit.

103 Larger modifications might require a higher funding level and a broader reform proposal. For example, the above-referenced hybrid proposal by Feder, et al, suggested restructuring public programs to serve all uninsured up to a certain income level, with employer tax credits covering uninsured workers at higher income levels.

104 One intermediate position supports Medicare-type benefits (perhaps with the addition of prescription drugs). Etheredge, 2001, op cit.; Etheredge, personal communication, October 2002.

105 One intermediate position supports Medicare-type benefits (perhaps with the addition of prescription drugs). Etheredge, 2001, op cit.; Etheredge, personal communication, October 2002.

106 The large gap between the proportion of employees at low-wage firms offered and those receiving employer coverage is due more to workers’ ineligibility for employer coverage than to low take-up rates. In low-wage firms (that is, those with workers at least 50% of whom earned low wages) offering health coverage, only 48.1% of workers were eligible for insurance; but fully 61.8% of those eligible for coverage enrolled. Id.

107 Such applications would not add greatly to administrative burdens if policymakers decide that tax credit applicants must obtain income determinations from Medicaid, SCHIP, or Social Security agencies (which are linked to Medicaid in determining eligibility for certain elderly and disabled applicants).

108 Without some such mechanism, states could shift beneficiaries into tax credits by either explicitly reducing coverage or making less obvious cuts through policy changes that increase eligibility denials for procedural reasons, reduce successful outreach strategies, make it harder for beneficiaries to retain coverage, etc. This Spring, California's response to budget pressures exemplified proposed cuts in both categories, more and less explicit. Governor Davis proposed rescinding eligibility for certain two-parent working families, to save \$92.1 million in state funds. The Governor proposed much greater savings -- \$155.4 million -- from asking beneficiaries to recertify eligibility every quarter, rather than every year. The Administration anticipated that many would be "discontinued for failure to complete and return these [quarterly] reports." California Department of Finance (DOF). *2002-2003 California Budget, Governor's May Revision*. May 14, 2002. http://www.dof.ca.gov/HTML/BUD_DOCS/MayRevise02w.pdf. DOF, *Governor's Budget Summary, 2001-2002*. January 2001. <http://www.dof.ca.gov/HTML/Budget01-02/Index.htm>. Tax credits without careful interface rules could encourage increased use of similar strategies with public programs.

109 The relevant group would need to be defined as tax credit recipients who would have qualified for Medicaid or SCHIP, under state law as it existed as some date before adoption of federal legislation. That way, states would have a disincentive to make cutbacks by changing state eligibility laws. A similar approach was used when TANF was created. To prevent states from denying Medicaid to families losing cash assistance, SSA Section 1931(b) required state Medicaid programs to cover individuals who would have qualified under the state's AFDC eligibility rules on a specified date before adoption of the legislation that created TANF.

110 See discussion of MEQC, above. A very different, administratively simpler approach to this issue would build on the current Medicaid/Medicare interface. Presently, Medicaid pays some premiums and out of pocket cost-sharing for various groups of Medicare beneficiaries with incomes up to 135 percent of FPL. For lower-income individuals qualifying for both Medicare and full-scope Medicaid, Medicaid also provides "wrap around coverage" of its services that Medicare does not cover. Along similar lines, policymakers could provide tax credit recipients, based on their income, with the same Medicaid cost-sharing and wrap-around arrangements that apply to Medicare.

This simpler approach has its disadvantages, however. States would retain financial incentives to shift low-income families into the tax credit program, since that would cut their financial responsibility from all services to just wrap-around services and some cost-sharing. As a result, a large proportion of tax credits could, rather than cover the previously uninsured, relieve states of prior coverage costs. Also, if several payments systems are responsible for different portions of a given consumer's care, coordination challenges could be coupled with incentives for each payor to shift costs to the other, potentially harming quality of care and raising total costs. In addition, some evidence indicates that the current Medicare/Medicaid interface does not effectively provide Medicaid protections to many low-income seniors, suggesting that beneficiaries could suffer under this alternative approach. Suzanne Felt-Lisk. *Helping Eligible Medicare Beneficiaries Access Medicaid: Lessons from SCHIP*. Mathematica. Monitoring Medicare Plus Choice, Operational Insights, September 2002, Number 9. <http://www.mathematica-mpr.com/PDFs/opinsights9.pdf>; Margo L. Rosenbach and JoAnn Lamphere. *Bridging the Gaps Between Medicare and Medicaid: The Case of QMBs and SLMBs*. Mathematica Policy Research, Inc., and AARP. January 1999. http://research.aarp.org/health/9902_qmbs.pdf; Michelle Kitchman, Tricia Neuman, David Sandman, Cathy Schoen, Dana Gelb Safran, Jana Montgomery, and William Rogers. *Seniors and Prescription Drugs: Findings from a 2001 Survey of Seniors in Eight States*. July 30, 2002. (Medicaid section.) <http://www.kff.org/content/2002/6049/6049.pdf>.

111 Expenditures for individuals who would have qualified under previous law can be excluded from grant funding using standard MEQC procedures, as discussed above. On a related issue, the extent to which health insurance grant funds could cover state matching requirements would depend on how much (if any) state match was required for the grant program. To create a level playing field among a state's policy options for grant implementation, the same, net state match would need to apply, regardless of which option the state chooses. For example, if the new federal grant program requires a 15 percent match from a given state, and that state's SCHIP program involves a 30 percent state match, the new grant could fund half the state's SCHIP match for an expansion group. Of course, public programs would provide an additional advantage, compared to other options on the menu, of offering at least some continuing federal matching funding after new grant funds run out in a given year. A similar dynamic applies to the choice, under SCHIP, between Medicaid and separate state programs.

112 For FY 2000 through 2002, these grants have totaled \$15 million per year. For more information, see Academy for Health Services Research and Health Policy. *State Planning Grants Program: Synthesis of State Experience - Interim Report*. December 2001. http://www.hrsa.gov/osp/stateplanning/hrsa03_2002.html. Many of the ideas in this section of the paper come from this report, particularly the section containing state recommendations to federal policymakers.

113 For example, the Robert Wood Johnson Foundation has funded a State Coverage Initiatives program that provides an average of \$2 million a year to inform states about expansion strategies and help states design and implement new coverage. <http://www.statecoverage.net/index.htm>.

114 Sharon Silow-Carroll, Emily K. Waldman, Heather Sacks, and Jack A. Meyer. *Assessing State Strategies for Health Coverage Expansion - Final Report*. ESRI 2002. Publication by The Commonwealth Fund Pending. LeAnne DeFrancesco, Christina Folz, Madeleine Konig, Carole Lee. *State of the States 2002*. Academy for Health Services Research and Health Policy. January 2002. <http://statecoverage.net/pdf/stateofstates2002.pdf>.

115 For examples, see Coughlin and Zuckerman, op cit.; U.S. General Accounting Office. *Medicaid: HCFA Reversed Its Position and Approved Additional State Financing Schemes*. GAO-02-147. October 2001, at pp. 5-6 (listing five evolving state strategies for accessing federal dollars, each of which provoked Congressional responses). <http://www.gao.gov>.

116 42 USC 1397gg(e)(1).

117 Similarly, to promote access to essential care without unduly inhibiting responsiveness and flexible benefit design, national rules could require that whatever services are included in the state plan must have sufficient coverage to reach their objectives. Such rules could likewise forbid discrimination in coverage based on diagnosis. Comparable requirements now apply under Medicaid when a state covers particular service categories. Perkins and Somers, op cit.

118 Countervailing safeguards may be needed to prevent plans from encouraging disenrollment of high-cost enrollees with significant health problems. More broadly, in deciding the level of choice offered to the formerly uninsured, policymakers need to balance the benefits of giving consumers the ability to tailor coverage to their individual needs against the impact on higher-risk individuals if lower-risk consumers tend to select less generous, lower-cost plans. This would leave middle-aged and less healthy workers disproportionately enrolled in more comprehensive plans, with resulting increases in premiums that could be significant.

119 H.R. 3009, op cit.

120 For example, the cap could be lifted to a somewhat higher level. Perhaps more important, the cap could be stated as a percentage of each state's allotment, not each state's spending, particularly during the first few years of the new grant program. As a program gets underway, administrative responsibilities are particularly extensive, and enrollees are relatively few. Accordingly, an unusually large proportion of program dollars is properly spent for administration during that period. Another way to account for such start-up costs would raise the cap in earlier years.

121 States could use non-coverage dollars to cover administrative costs, including eligibility determination, related computer improvements, outreach, and development of pools, purchasing cooperatives, and similar mechanisms. Federal policymakers may need to decide the proportions of grants to earmark for various purposes and the minimum requirements that should apply to state administration, including whether and to what extent states may use grant funds to pay health care providers directly, to sustain or improve health care infrastructure in underserved communities.

122 A related question is whether states may cover immigrants residing indefinitely in the United States, with the knowledge and permission of the INS, who nevertheless fall outside the specific categories listed in TANF legislation (categories that Medicaid and SCHIP incorporate).

123 Medicaid coverage provided pursuant to 1115 waivers would not qualify for any such deemed status, because such waivers frequently render inoperative federal safeguards for benefits, cost-sharing, and other matters.

124 Embry M. Howell, Jeffrey A. Buck, and Judith L. Teich. "State Report: Mental Health Benefits Under SCHIP." *Health Affairs*. November/December 2000. <http://130.94.25.113/readeragent.php?ID=/usr/local/apache/sites/healthaffairs.org/htdocs/Library/v19n6/s34.pdf>; Harriette B. Fox, Margaret A. McManus, and Stephanie J. Limb. *Access to Care for SCHIP Children with Special Health Needs*. Kaiser Commission on Medicaid and the Uninsured. December 2000. <http://www.kff.org/content/2000/2226/2226.pdf>.

125 Put differently, the question is whether new grant funds can help pay for coverage available under prior state law or whether such funds are limited to new coverage groups that previously were ineligible.

126 Not only could it reduce the number of uninsured, such an alternative approach would also provide additional help to states that, before new federal legislation, had already expanded coverage generously. This would help address the equity issues discussed above.

127 Such a compromise could also be structured to permit these states to use new grant funds to cover related caseload increases, regardless of eligibility category. Identifying which caseload increases are related could be challenging, however.

128 In theory, federal policymakers could establish federal matching percentages that increase automatically during recession. That would increase support for states when federal assistance tends to be most needed and provide automatic, countercyclical help. However, it would also make federal funding amounts less predictable for states, complicating state decision-making.

129 42 U.S.C. 1397hh.

130 David Lansky. "Improving Quality through Public Disclosure of Performance Information." *Health Affairs*. July/August 2002. <http://130.94.25.113/readeragent.php?ID=/usr/local/apache/sites/healthaffairs.org/htdocs/Library/v21n4/s34.pdf>. 42 U.S.C. 1397hh, 1397ii.

131 42 U.S.C. 1397bb.

132 42 U.S.C. 1397gg.

133 42 C.F.R. 431.200 – 431.500.

134 Mills, op cit. Along similar lines, earlier data showed that more than 7 million uninsured had income above 300 percent of FPL. Kaiser Commission on Medicaid and the Uninsured. *The Uninsured: A Primer. Key Facts About Americans Without Health Coverage*. March 2002. <http://www.kff.org/content/2002/4050/4050.pdf>.

135 In practice, the number receiving coverage would be less than the maximum potential numbers shown in Figure 5. Fewer uninsured are covered if few take up subsidies, if the allotted funding pays for administrative costs, etc.

136 Gary A. Smith. *Status Report: Litigation Concerning Medicaid Services for Persons with Developmental and Other Disabilities*. Human Services Research Institute. July 13, 2002. <http://www.healthlaw.org/pubs/LitigationStatusJuly2002.doc>.

137 For an example, see National Governors Association. *HR-16. Medicaid Policy*. Revised Winter Meeting, 2002. http://www.nga.org/nga/legislativeUpdate/1,1169,C_POLICY_POSITION%5ED_533,00.html

Economic and Social Research Institute
1015 18th Street, N.W., Suite 210
Washington, DC 20036
202 833-8877