



INSTITUTE FOR HEALTH POLICY SOLUTIONS

Treatment of Flexible Benefit Plans Under Employer Coverage Subsidy Programs

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A number of states are developing programs to assist parents with the cost of obtaining employer-sponsored coverage for their children. These premium subsidy or buy-in programs may be implemented as part of the Child Health Insurance Program (CHIP) established by the Balanced Budget Act of 1997. The Act allows subsidies for an employee's required contribution for coverage of a child not already enrolled under the employer's plan. The cost must be no more than would have been incurred if the same child were enrolled under the state's regular CHIP program.

States designing buy-in programs face a number of administrative issues, including developing payment mechanisms, assessing cost-effectiveness, and assuring access to required minimum CHIP benefits. Special issues are posed by cases in which employees have access to cafeteria plans or other flexible benefit arrangements. This paper describes the types of flexible benefit plans offered by employers, provides data on the prevalence and common features of such plans, and considers their implications for buy-in programs.

What are flexible benefit plans?

Flexible benefit plans allow employees to choose among tax-exempt fringe benefits, or to choose between receiving taxable income, taxable benefits, or tax-exempt benefits. If the plan simply allows the employee to choose from among different tax-exempt benefits that will be paid for by the employer—for example, health insurance or group term life insurance—the plan as a whole is tax-exempt because each included benefit is tax-exempt. Special rules apply, under section 125 of the Internal Revenue Code, when the employee can choose between tax-exempt benefits and cash or taxable benefits.

There are two basic types of section 125 plans, cafeteria plans and flexible spending accounts. (Section 125 actually defines only one type of plan, a cafeteria plan. Flexible spending accounts are a variant that has been developed under the section 125 rules.)

Cafeteria plans. Under a cafeteria plan, an employee may choose to apply employer-contributed funds to different benefits (for example, health insurance, dental insurance, assistance with child

care, or term life insurance) and/or different levels of benefits (for example, an HMO or an indemnity plan, or different dollar amounts of life insurance).¹ Frequently, the employee will be given a fixed budget—dollars or credits—to be distributed among different benefits. If the employee selects a package of benefits that costs more than the budgeted amount, the employee pays the difference (either with after-tax dollars or through a flexible spending account; see below). In some plans, if the employee selects a package that costs *less* than the budgeted amount, the employee may receive some of the balance in cash. Any cash pay-out is taxable; often the amount is some fraction, such as 50 percent, of the unused balance. Other plans require that all credits be used for benefits.

Cafeteria plans differ in their treatment of health insurance. In some plans, health insurance is simply one of the benefits available; the employer's contribution to health premiums is subsumed in the overall contribution to the cafeteria plan. In other cases, an employer may fund a basic level of health coverage for employees outside the cafeteria plan, so that the employee is then choosing between enhancements to that coverage (such as a more comprehensive plan or an indemnity option) and alternative benefits or cash. The plan may require that every employee take the basic health coverage or may allow the employee to waive it and receive a larger credit for alternative benefits; some plans allow a waiver only if the employee demonstrates coverage from another source. Similar rules may apply to dependent coverage: the employee may be required to accept it or may be allowed to waive it, with or without evidence of other coverage for family members.

That a benefit is available through a cafeteria plan does not necessarily mean that the employer will pay for it in full. There may still be a required employee contribution. For example, an employer might pay for employee-only health coverage in full and then offer a 50 percent contribution to dependent coverage as one of the options under the cafeteria plan. An employee selecting this option would then have to pay the remaining 50 percent of the cost of dependent coverage.

Flexible spending accounts (FSAs). Under an FSA arrangement, an employee can purchase certain benefits on a tax-preferred basis. The employee designates a sum to be deducted from his or her wages and deposited into an FSA; the amount deposited is non-taxable. The employee may draw on the account to pay for his or her share of health premiums, to pay coinsurance or deductible requirements under the health plan, or to pay for medical services not covered under the plan—for example, dental care or eyeglasses. Or the FSA may be available for other types of expenses, such as child care or care of a disabled relative. (Some plans allow an employee to establish more than one FSA—for example, one for medical expenses and one for child care.) Some plans are known as **premium conversion** or **premium-only plans (POPs)**; in these plans, the FSA may be used only to pay the employee's share of health premiums.

There are two key differences between FSAs and cafeteria plans. First, the employee and not the employer determines the amount to be deposited in the FSA (up to any limit established by the employer). Second, FSAs are subject to a “use it or lose it” rule. If the employee does not spend

¹ Some cafeteria plans may include fringe benefits that are not tax-exempt (such as whole life, rather than term life insurance). If an employee selects one of these benefits, the value is included in the employee's taxable income.

the full amount of the FSA for tax-exempt benefits during the year, he or she does not receive the difference as wages; instead the unspent amount reverts to the employer. This rule has little importance for POPs: as the employee knows in advance the required premiums, he or she can designate the exact amount to be placed in the account. However, when an account is available for other kinds of medical spending, the employee must guess about his or her future expenses. If the employee underestimates, excess costs must be paid for out-of-pocket. If the employee overestimates, he or she loses the unexpended balance in the account.²

Table 1. Examples of a Cafeteria Plan and a Flexible Spending Account

	Firm X Cafeteria plan		Firm Y FSA	
	Employee A	Employee B	Employee C	Employee D
Salary	\$ 23,000	\$ 23,000	\$ 25,000	\$ 25,000
Amount available for benefits	\$ 2,000	\$ 2,000	\$ 2,000	\$ 1,000
Cost of benefits used	\$ 1,500	\$ 2,500	\$ 1,500	\$ 1,500
Balance	\$ 500	\$ (500)	\$ 500	\$ (500)
Employee net earnings	\$ 23,500	\$ 22,500	\$ 23,000	\$ 23,500
Taxable amount	\$ 23,500	\$ 23,000	\$ 23,000	\$ 24,000

Table 1 illustrates the differences in the two types of arrangements. Firm X has established a cafeteria plan with a \$2,000 budget for each employee. Firm Y allows each employee to establish an FSA of up to \$2,000. Note that the employees in each firm could have maximum taxable wages of \$25,000. An employee in Firm X could choose not to receive any fringe benefits, and would thus receive the \$2,000 as additional wages, bringing total income to \$25,000.³ An employee in Firm Y could choose not to establish an FSA, and would then receive the original \$25,000 in wages.

Under the cafeteria plan, **Employee A** selects \$1,500 worth of benefits and receives the remaining \$500 as wages, resulting in total taxable income of \$23,500. **Employee B** chooses a package of fringe benefits whose cost exceeds the \$2,000 budget. The \$500 excess is paid by the employee through weekly payroll deductions. These deductions come from after-tax dollars (just as employee premium contributions come from after-tax dollars in the absence of a section 125 plan). Thus the employee receives only \$22,500 in net wages, but has \$23,000 in taxable income.

² There are proposals to allow workers to roll over unexpended balances in FSAs to cover expenses in future years. See Robert E. Moffitt and William W. Beach, "Rollover Flexible Spending Accounts: More Health Choices for Americans," *The Heritage Foundation Backgrounder*, n. 1159, Feb. 24, 1998.

³ In practice, many cafeteria plans with cash pay-out options pay something less than the value of the forgone benefits. For example, a worker who underspends by \$500 might receive half that amount in additional wages.

Under the flexible spending arrangement, **Employee C** chooses to deposit \$2,000 in the FSA, reducing wages to \$23,000. However, the employee has overestimated his or her medical expenses for the year and actually uses only \$1,500. The balance in the FSA reverts to the employer. **Employee D** deposits only \$1,000 in the FSA, but has expenses of \$1,500. The employee must pay these additional costs out-of-pocket using after-tax dollars. As a result, the employee has net income of \$23,500: the \$24,000 in wages remaining after the FSA deposit, less the excess \$500 in out-of-pocket medical costs. Taxable income, however, is \$24,000.

Despite the differences between cafeteria plans and FSAs, there might be instances in which their net financial effect on the employee is the same. For example, a cafeteria plan that offers a choice between enhanced health coverage and cash is really no different from an FSA arrangement under which the employee can use the FSA to purchase enhanced health benefits. In either case, the employee is choosing between higher taxable wages or reduced wages plus a tax-exempt benefit.

Finally, some employers offer both a cafeteria plan and an FSA. Under these arrangements, an employee who selects a package of benefits exceeding the cafeteria plan budget may pay for the excess out of pretax dollars by using the FSA (so long as each benefit is tax-exempt). Or the employee may use the FSA to pay for benefits that are not covered under the cafeteria plan. In some cafeteria plans that offer the employee a fixed dollar budget, the employee may be able to deposit any dollars not used for benefits into an FSA.

How common are section 125 plans?

Tables 2 and 3 show the availability of section 125 plans for full-time workers in private establishments and in state and local government.⁴ (Federal workers do not have access to a section 125 plan.) As the table indicates, FSAs or premium conversion plans are much more commonly available than cafeteria plans. While cafeteria plans are more widely available in larger establishments, they are less likely to be available to blue collar and service employees.

Table 2. Percent of Full-Time Workers in Private Establishments Eligible for Section 125 Plans, 1994-95

	Any section 125 plan	Cafeteria plan	Premium conversion plan	Other free-standing FSA
Small establishments (under 100 workers), 1994				
All employees	19	3	6	10
Professional, technical, and related employees	28	2	10	16
Clerical and sales employees	24	5	6	13
Blue collar and service employees	13	2	5	6
Medium and large establishments (100 or more workers), 1995				
All employees	55	12	5	38
Professional, technical, and related employees	77	20	4	53
Clerical and sales employees	66	15	5	46
Blue collar and service employees	37	7	5	25

Note: Many cafeteria plans include an FSA option.

Source: IHPS analysis of data from U.S. Department of Labor, Bureau of Labor Statistics, *Employee Benefits in Small Private Industry Establishments, 1994*, Washington, 1996, and *Employee Benefits in Medium and Large Private Industry Establishments, 1995* (advance release of tables, 1998).

⁴ An establishment is defined by BLS as an “economic unit that produces goods or services...at a single location.” Because a single firm can operate in multiple locations, some “small” establishments are actually part of medium or large firms.

Table 3. Percent of Full-Time Workers in State and Local Government Eligible for Section 125 Plans, 1994

	Cafeteria plan	FSA
All employees	5	64
White collar employees, except teachers	5	68
Teachers	7	59
Blue collar and service employees	3	61

Source: U.S. Department of Labor, Bureau of Labor Statistics, "BLS Reports on Employee Benefits in State and Local Governments, 1994," press release, Sep. 14, 1995.

While FSAs are widely available even in smaller establishments, the extent to which they are available to modest-income workers is uncertain. Table 4 provides one indirect measure: the extent to which FSAs are available in firms with different proportions of workers earning \$20,000 a year or more. While FSAs are somewhat more common in firms with a higher proportion of high-wage workers, the difference is not marked. Note that the data are restricted to workers in firms that offer health insurance. What the figures suggest is that, if a low-wage firm offers health benefits, it is about as likely as any other firm to offer an FSA.

Table 4. Workers Offered FSAs by Percent of Workers in Firm Earning \$20,000 or More Per Year, 1993

Percent of workers earning \$20,000 or more per year	Offered FSA	No FSA	Percent with FSA
0-9%	1,924,783	3,249,951	37.2%
10-19%	720,189	1,264,169	36.3%
20-29%	650,188	1,200,040	35.1%
30-39%	345,936	800,562	30.2%
40-49%	496,566	659,254	43.0%
50-59%	470,727	748,139	38.6%
60-69%	649,070	795,597	44.9%
70-79%	775,953	969,894	44.4%
80-89%	783,353	879,523	47.1%
90-99%	1,135,146	927,341	55.0%
100%	710,161	1,166,755	37.8%
Total	8,662,072	12,661,225	40.6%

NOTE: Data include only firms offering health insurance.

Source: IHPS analysis of data from the 1993 Robert Wood Johnson Foundation Employer Health Insurance Survey.

Not all FSAs are available for payment of the employee share of health insurance premiums. Table 5 shows the types of spending for which employees may use their FSAs. Note that the table is restricted to FSAs that are *not* premium-only plans. As table 2 indicated, premium-only plans are slightly more common in smaller establishments.

**Table 5. Percent of Workers Eligible for FSAs
(Other than Premium-Only Plans)
Who May Use the FSA for Specified Purposes**

	Small establishments, 1994	Medium and large establishments, 1995
Health premiums	63%	56%
Other health expenses	81	78
Dependent care expenses	82	77
Legal expenses	2	*
Other premiums	**	10
Other	**	2
Expenses not determinable	2	5

*Less than 0.5 percent

**Category not included in small establishment data

NOTE: Data for small establishments include premium-only plans and FSAs available as part of a cafeteria plan; data for medium and large establishments include only freestanding FSAs that are not premium-only plans. Columns sum to more than 100 percent because many plans allow FSAs to be used for multiple purposes.

Source: IHPS analysis of data from U.S. Department of Labor, Bureau of Labor Statistics, *Employee Benefits in Small Private Industry Establishments, 1994*, Washington, 1996, and *Employee Benefits in Medium and Large Private Industry Establishments, 1995* (advance release of tables, 1998).

It is not clear to what extent employers who have reduced their contributions to health insurance premiums are offering FSAs as an alternative way of providing their employees with tax-exempt financing for premiums. Table 6 shows the availability of FSAs to workers whose employers are paying different shares of family premiums. It appears that workers with low employer contributions were somewhat *less* likely to be able to make up the difference through an FSA. Note that, for employers offering multiple health plans, the percentage shown is the maximum employer contribution available for any plan. This may include cases in which the employer is paying most or all of the cost of the least expensive plan; an employee might then use the FSA to obtain more costly coverage.

Table 6. Workers with Access to Flexible Spending Accounts by Maximum Employer Contribution to Family Health Premium, Ten States, 1993

Employer share of family premium	Offered FSA	No FSA	Percent with FSA
0-9%	397,467	1,206,593	24.8%
10-19%	68,071	188,744	26.5%
20-29%	324,843	395,095	45.1%
30-39%	284,036	923,914	23.5%
40-49%	312,367	501,904	38.4%
50-59%	405,233	1,373,917	22.8%
60-69%	947,865	897,681	51.4%
70-79%	1,334,951	1,750,297	43.3%
80-89%	1,133,220	1,118,917	50.3%
90-99%	819,762	1,117,671	42.3%
100%	2,634,256	3,186,491	45.3%
Total	8,662,072	12,661,225	40.6%

Source: IHPS analysis of data from the 1993 Robert Wood Johnson Foundation Employer Health Insurance Survey.

It should be emphasized that all of these data are some years old. In the last few years, payroll management firms, employee benefits advisers, and others have been making more employers aware of the potential advantages of flexible spending arrangements. There are anecdotal reports that the use of such arrangements, particularly premium-only plans, has increased among smaller firms. For example, one payroll management company contacted by IHPS reports that enrollment in the flexible benefit plan it manages has doubled in the last five years.

How might flexible benefit plans affect subsidy programs for the employee share of child health premiums?

Section 125 plans are sufficiently common that states will need to consider their implications for premium subsidy programs. Cafeteria plans take so many different forms that a policy that attempted to account for every variation might be unworkably complex; the following discussion will merely attempt to highlight some key issues. FSAs pose fewer problems, but may have some implications for subsidy payment mechanisms.

Cafeteria plans

For the purpose of a subsidy program, it may be useful to distinguish between two broad types of cafeteria plans:

1. Those in which employees can waive health coverage for themselves and/or dependents and receive some or all of the value in cash. This will be referred to here as a “cash-out” plan.
2. Those in which employees can only choose from among different benefits. This will be referred to as a “benefit-only” plan.

Establishing employer contributions. Under federal guidance to state CHIP programs, a state may generally subsidize the employee share of premiums only if the employer is contributing at least 60 percent of the cost of family coverage. A state may use a lower threshold if it has other provisions to discourage reductions in employer contributions.⁵ A state must, then, establish both the total cost of family coverage and the amount of the employer’s contribution.

A state will also need to determine the employer’s contribution if, like Massachusetts and Oregon, it requires that parents accept available employer coverage for their children; a child for whom coverage is declined may not be enrolled in the public program. In Massachusetts, this rule applies whenever the employer is contributing at least 50 percent of the cost of coverage. In Oregon, it applies if the employer is contributing any amount toward coverage.⁶

What is the employer contribution in a cafeteria plan? Consider a plan in which the total cost of family coverage is \$5,000. An employee may select family coverage under the cafeteria plan and will then pay \$100 a month (or \$1,200 per year) for this coverage. Or the employee may waive family coverage and receive other benefits or a cash pay-out; the maximum cash pay-out is \$1,000.

In one view, the employer contribution is the *maximum* contribution to health insurance available to the employee through the plan, assuming that the employee selects health benefits in lieu of other benefits or cash. In this case the maximum is \$3,800 (\$5,000 less the required employee contribution), or 76 percent, well above the 60 percent threshold. Alternatively, because the employee could have received cash instead of benefits, one might say that an employee who selects family coverage is really paying \$2,200: the \$100 a month employee contribution plus the forgone \$1,000 pay-out. In this view, the employer contribution is only \$2,800, or 56 percent of the family premium.

A case can be made for either perspective. The available cash pay-out could be regarded as simply a sort of bonus for waiving coverage; the employee who chooses family coverage has received a benefit and has not really lost anything. Or the pay-out could be regarded as part of the employee’s total available compensation; the employee who selects family coverage has in effect spent part of his or her wages. (This is in fact the federal view with respect to low-income families who are potentially eligible for the Earned Income Tax Credit, or EITC. If a worker with a choice between benefits and cash opts for the benefits, the available cash pay-out is nevertheless included in gross income for the purpose of determining eligibility for, and the amount of, the credit.)

⁵ Letter to state officials from Sally Richardson, Health Care Financing Administration, and Claude Earl Fox, M.D., M.P.H., Health Resources and Services Administration, Feb. 13, 1998.

⁶ Massachusetts is able to use a 50 percent threshold because its program is being operated under a section 1115 Medicaid demonstration waiver. Oregon’s buy-in program is at this point entirely state-funded and thus not subject to the CHIP rules.

This dilemma may present itself even in a benefit-only plan. Even when the choice is between dependent health coverage or other tax-free benefits, the alternative benefits might be just as important as health insurance to low-income workers and their families. For example, if a parent may choose between dependent coverage and assistance with child care costs, requiring that the parent select health insurance would then mean that the parent would have to pay more out-of-pocket for child care.

Massachusetts has tentatively decided to treat all employer dollars available for health benefits as the employer contribution, even if some of that contribution is made only under the cafeteria plan. Whatever the equity arguments for the opposite approach, this is probably more practical administratively. The state needs to establish only (a) the total cost of family coverage and (b) the direct premium contribution required by the employee to obtain this coverage.⁷ The employer contribution is simply (a) minus (b).

If a state instead chooses to regard a health benefit available under a cafeteria plan as being paid by the employee—because it substitutes for cash or other benefits—it may face a much more complex computation. First, it may be difficult to value the benefit. In the illustrative plan cited earlier, which provides a maximum cash pay-out of \$1,000, should the state assume that an employee who selects family coverage is spending the entire \$1,000 on that coverage, or might some of it be going to other benefits? What about cases in which the maximum cash pay-out for an employee who waives benefits is less than the value of the waived benefits?

The state would also have to decide the amount of the premium subsidy for which the family would be eligible. Again using the illustrative plan discussed earlier, is the family entitled to \$1,200 or \$2,200 (assuming that either amount is below the maximum available subsidy under the state's cost-effectiveness test)? And, if the state assumes that the \$1,000 in forgone pay-out is in effect spent income, does this mean that the employee's gross income—for the purpose of program eligibility or a sliding-scale determination—is really \$1,000 higher than his or her actual wages?

Again, simplicity would seem to dictate the approach adopted in Massachusetts, even if some families are arguably left worse off under this approach. As was suggested earlier, the number of low-income workers with access to cafeteria plans is probably relatively small, and the number in plans with a cash-out option may be even smaller. Attempts to hold such families harmless may not be worth the very substantial administrative burden.

Benefits. When benefits under an employer plan are not substantially equal to those under a benchmark plan established by the state, the state must make up the difference by providing a supplemental plan or by making arrangements with the employer or carrier to provide supplemental coverage. A state must also assure that cost-sharing for a child required under an employer plan does not exceed the cost-sharing that the state may impose under CHIP rules, either by arranging supplemental coverage for the child or by reimbursing the family.

⁷ It may be that the state does not even need to establish the total cost of coverage. The federal policy guidance on CHIP suggests that a state might be able to use a limit on the dollar amount of the employee's contribution as a proxy for the 60 percent test.

Under a cafeteria plan, a parent may be able to choose more comprehensive health coverage than the employer's basic plan, or may be able to obtain a separate plan, such as dental insurance, that provides some of the supplemental benefits the state would otherwise have to furnish. The state will need to decide whether the parent is expected to obtain the maximum health benefits available under the cafeteria plan, in order to reduce the state's financial exposure for supplemental coverage.

Actually, this issue may arise outside the context of cafeteria plans. Many employees without cafeteria plans still have the opportunity to select a preferred or high-option health plan in return for a higher employee contribution. Others may be able to obtain dental or vision plans, again by paying an extra contribution. In theory, a state buy-in program might wish to consider assisting families with these higher premiums, if they are offset by the potential savings in supplemental benefit costs.

In practice, such a policy would require assessing the actuarial value of every benefit package available to families in multiple-choice settings and determining which was the most cost-effective to subsidize. Moreover, it is likely that a high-option plan will rarely be a bargain for the state. Sometimes the high-option plan is a fee-for-service or point-of-service option that actually imposes higher cost-sharing than the employer's basic plan. Even when this is not so, high-option plans may tend to attract sicker enrollees, so that the excess premium may be greater than the value of the extra benefits for an average child. Supplemental vision and dental plans may be even less cost-effective, since the state would usually have to buy coverage for the adult(s) in the family in order to cover children.

These calculations may be very different when the added benefits are available through a cafeteria plan, particularly if there is no direct cost to the employee. If the state required the employee to select the most generous coverage available, it might reduce its financial exposure for supplemental benefits without increasing its premium subsidy costs. However, this policy would raise issues comparable to those presented earlier, in the discussion of measuring employer and employee contributions. The employee who selects the most generous health coverage is forgoing other valuable benefits or possibly cash.

In the earlier discussion, it was suggested that administrative simplicity might outweigh any equity concerns raised by a requirement that a parent choose dependent health coverage in lieu of other benefits. The trade-off is less clear in the case of a requirement that the parent maximize available benefits for the child when to do so would bring coverage closer to the required benchmark. Again, the state would have the administrative burden of assessing which option or combination of options under a given employer's system was most cost-effective. In addition, because it may be that no available option provides the full minimum benefits required under CHIP rules, the state might still have to operate or arrange some form of wrap-around coverage for the child.

Flexible spending accounts

Employees with access to FSAs may realize a net reduction in their premium contributions for health benefits, because those contributions can be made from pre-tax dollars. Consider a case in which a mother must contribute \$100 a month to cover her children and may make this contribution by establishing an FSA. The \$100 per month deducted from her pay reduces her taxable income both for federal income tax and for FICA (Social Security and Medicare). Assuming she is in the 15 percent tax bracket, her combined tax savings are \$22.65, reducing the net cost of her contribution to \$77.35.

If a state chooses to subsidize employee premium contributions, it would make sense to take advantage of these potential savings whenever possible. The state could reduce its subsidy, potentially freeing funds to cover more children, with no net effect on the parent. Whether this is actually feasible may depend on the state's general system for administering premium subsidies.

States choosing to subsidize employee premium contributions may (a) make arrangements directly with employers or insurers to reduce or eliminate the contribution that would otherwise be deducted from parents' wages; or (b) allow the full deduction to occur and then reimburse parents for their contributions, either prospectively or retrospectively.⁸ An approach that does not involve employers in the payment process has several advantages. For instance under (b), employers would not be required to perform additional for which they are essentially receiving no additional benefit. Also, by having employers aware of the subsidy, employers have a greater opportunity to alter their contribution policies and increase the likelihood of a "crowding-out" of employer contributions. Finally, an employer approach places employers in the awkward situation of differentially treating employees of similar incomes.

If the state chooses the first option, paying the subsidy directly to the employer or insurer, it will reduce the gross contribution required from the employee and hence the potential for tax savings. In the example cited, if the state paid a \$50 subsidy to the employer, the employee's required contribution would be reduced to \$50. If the employee paid this amount through an FSA, the tax savings would be just \$11.33. Moreover, the state would somehow have to recapture these savings from the parent.

It might be possible to adjust the subsidy formula so that what the state paid to the employer or insurer already reflected the availability of tax savings. For example, if the state's plan is to require a parent at a given income level to pay a net \$50 toward coverage, the state could pay the employer \$35.36, leaving the employee with a gross liability of \$64.64. If the employee paid this amount through an FSA, the tax savings of 22.65% would reduce her net liability to \$50.⁹

However, there is at least one major complication: there are families for whom the FSA would not in fact reduce federal income tax liability, because the family's income was below the taxable level to begin with. For example, a couple with two children and income below \$17,500 in 1997 would have owed no income tax after taking the standard deduction and four

⁸ For an overview of the payment options, see Jean Hearne, *Alternate Approaches for Paying Child Health Insurance Subsidies*, IHPS, Jan. 1998.

⁹ Note that the net savings to the state might be reduced if the FSA arrangement also reduced the mother's state income tax, although not all states follow the federal policy of excluding FSA contributions from taxable income.

exemptions. Other families with incomes above the tax threshold would receive only partial savings. For example, a family with \$18,000 in income that put \$1,000 into an FSA would not save \$150 (15 percent), but \$75, because only their last \$500 in gross income would have been taxable in the first place. (Both families would realize savings in their FICA liability.)

To take advantage of the FSA, then, the state would have to ascertain the net tax effect for each individual family. It is possible that this could be done on a simple formulaic basis. (The formula would probably have to assume that the family took the standard deduction, even though there are some low-income families who do itemize.) Still, taking account of FSAs is likely to increase the administrative complexity of the buy-in program.

Realizing savings through an FSA may be more feasible if the state adopts the second method of administering subsidies—under which the parent would make the premium contribution and then receive reimbursement. The mother would pay the full \$100 at a net after-tax cost of \$77.35. If the mother was eligible for a full premium subsidy, the state would reimburse the net \$77.35. If she was eligible for a partial subsidy, the reimbursement might be reduced on some pro rata basis. Here again, there is a potential problem in ascertaining the true after-tax liability for the parent; it cannot simply be computed from a paystub. Again, some simple formula for reducing subsidy amounts might be possible, at the risk of penalizing some families with exceptional tax situations.

The discussion to this point has assumed that the state wishes to recover the potential tax savings instead of allowing the parent to retain them. At least one state is instead considering an arrangement under which the state would make the same subsidy for eligible children that it would otherwise make, and would allow the parent to use the tax savings to help finance his or her own coverage.

For example, suppose that an uninsured mother could obtain employer coverage for herself by paying \$50 a month, and could add her two children by paying another \$100 per month. Suppose that the state's maximum subsidy per child is \$50. The mother could pay out the full \$150 employee contribution for family coverage through an FSA, incurring a net after-tax cost of $\$150 \times .7735$, or \$116. The state would pay the mother the maximum \$100 subsidy for the two children. Her net cost for covering herself would, then, be only \$16.

In effect, the CHIP subsidies and the tax savings become two funding streams which, in combination, help make coverage affordable for an entire family. The state considering this option hopes that it might even encourage some employers who are not now offering coverage to do so. Even if the employer made only a nominal contribution, the combined subsidies might reduce the net cost of family coverage to levels at which low-income families would be willing to participate.

This assumes that federal regulators will in fact regard the two funding streams as separate. If one considers the tax savings as applicable to coverage for both the parent and the children, the state's \$100 subsidy would exceed the actual net cost of covering the children. This might be acceptable so long as the state showed that the subsidy was still less than would have been spent

if the children had enrolled in the regular CHIP program. However, the state might be required to apply for a family coverage variance.

Note that this approach works only under the second of the two administrative options, under which the parent makes the contribution first and then receives reimbursement from the state. Again, if the state instead pays the subsidy directly to the employer or insurer, it will reduce the gross contribution required from the employee and hence the potential for tax savings.