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Individual Tax Credits and Employer Coverage: Assessing and Reducing the Downside Risks

Based on an INSTITUTE FOR HEALTH POLICY SOLUTIONS

Expert Forum

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1444 EYE STREET NW, SUITE 900
WASHINGTON, DC 20005
202-789-1491 • FAX: 202-789-1879
WWW.IHPS.ORG

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Individual Tax Credits and Employer Coverage: Assessing and Reducing the Downside Risks

On April 19, 2002, the Institute for Health Policy Solutions convened an expert forum to consider the interface between the proposed individual tax credit and employment-based health insurance. The goals were to identify where and why the tax credit might cause some people to become uninsured due to loss of their employment-based coverage and to generate constructive ideas for tax-credit modifications to minimize that loss and expand coverage of the uninsured. The distinguished discussants, who contributed a wealth of expertise from varying perspectives, were:

Henry Aaron, Ph.D., *Senior Fellow, The Brookings Institution*
Katherine Baicker, Ph.D., *Senior Economist, President's Council of Economic Advisers*
James Baumgardner, Ph.D., *Dep. Assist. Director, Congressional Budget Office*
Linda Blumberg, Ph.D., *Senior Research Associate, The Urban Institute*
Stuart Butler, Ph.D., *Vice President, The Heritage Foundation*
Cecil Bykerk, F.S.A., *Executive Vice President and Chief Actuary, Mutual of Omaha*
Lynn Etheredge, *The Health Insurance Reform Project, George Washington University*
Steve Finan, *Office of the Assistant Secretary for Planning and Evaluation, HHS*
Bill Hagens, *Senior Health Policy Adviser, Washington State DSHS*
Bob Helms, Ph.D., *Director of Health Policy Studies, American Enterprise Institute*
Richard Hinz, *Director, Office of Policy and Research, PWBA, Dept. of Labor*
Gillian Hunter, *Financial Economist, Office of Tax Analysis, Dept. of the Treasury*
Larry Levitt, *Vice President, Kaiser Family Foundation*
Robert Lyke, *Specialist in Social Legislation, Congressional Research Service*
Jim Mays, *Vice President, Actuarial Research Corporation*
Mark McClellan, M.D., Ph.D., *Member, President's Council of Economic Advisers*
Jack Meyer, Ph.D., *President, Economic and Social Research Institute*
Len Nichols, Ph.D., *Vice President, Center for Studying Health System Change*
Mark Pauly, Ph.D., *Chairperson, Health Care Systems Department, The Wharton School*
Joe Piacentini, *Deputy Director, Office of Policy and Research, PWBA, Dept. of Labor*
Ray Scheppach, Ph.D., *Executive Director, National Governors' Association*
Andrew Scott, *Budget Examiner, Office of Management and Budget*
John Sheils, *Vice President, The Lewin Group*
Gene Steuerle, Ph.D., *Senior Fellow, The Urban Institute*
Patricia Stromberg, *Dep. Comm. for CHIP and Adult Basic Cov., PA Dept. of Insurance*
John Troy, *Public Policy Consultant*

- Moderated by -

Rick Curtis, *President, Institute for Health Policy Solutions*

This report was prepared by Lynn Taylor and Rick Curtis, Institute for Health Policy Solutions. It is based on the discussion (including clarifying comments participants made in the course of reviewing the draft paper) and attempts to arrange the most salient insights into a useful format. It also draws on background information and analysis developed by Ed Neuschler, Senior Program Officer, and Lynn Taylor, Senior Policy Analyst at IHPS. While participants graciously shared their expertise and insights freely, achieving a formal consensus was not a goal of the meeting.

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Executive Summary

There has been considerable interest and debate concerning the Bush administration's proposed income tax credit for individual health insurance. In April 2002, the Institute for Health Policy Solutions (IHPS) convened an expert forum with two dozen distinguished panelists to explore one key aspect of the proposed policy: the interface between the proposed tax credit and employment-based health insurance.

The proposed tax credit would pay a maximum of 90% of the premium amount for non-group health insurance, up to a cap of $1,000 per adult and $500 per child, with a two-child maximum and a $3,000 family maximum. To be eligible for the maximum tax credit, single filers must have incomes of $15,000 or less; other filers must have incomes of $25,000 or less. The income eligibility level for the maximum tax credit corresponds to between 138% and 209% of the poverty level (depending on family structure); the income eligibility level for a 50% tax credit would extend well above 200% of the poverty level. Significant for the focus of this meeting, the proposed tax credit *cannot* be used to purchase coverage under public or employer-provided health plans.

The April 2002 forum specifically addressed whether this proposed tax credit might cause some workers and dependents who currently have employment-based coverage to become uninsured, and what policy variations might minimize that downside risk. The goals were to brainstorm about the extent of the risk, to understand the factors involved, and to generate constructive ideas for tax credit modifications that reduce the risk, thereby increasing health insurance coverage for the uninsured. To focus on achieving these goals, the meeting did not address other related issues such as reform of the individual market or major public program expansions. And, for purposes of the discussion, participants agreed to assume that market constructs would be in place such that the non-group market would function in a socially acceptable way, and carriers could participate in the market and remain viable.[1]

Who Might Drop Coverage

The distinguished panel participants generally agreed on the characteristics of workers most likely to switch coverage voluntarily in response to the proposed tax credit:

- **Younger, healthy workers with incomes low enough to obtain the maximum $1,000 tax credit** would be most likely to drop out of their employer-sponsored group health insurance plan in favor of using the tax credit toward individual coverage. For these workers, the credit typically would cover most of the premium for a basic, $500- or $1,000-deductible individual health insurance policy.

The expert participants also generally agreed on which kinds of firms are most likely to drop existing coverage in response to the proposed tax credit:

[1] For example, mechanisms such as an accessible, adequately funded high-risk pool or market access and rating rules.

- **Small firms with a significant portion of workers who could qualify for the maximum tax credit**—and who currently realize lower tax subsidies for employer-sponsored coverage—would be most likely to drop their employer group plan or reduce their contributions. Other employers might subsequently drop coverage, either after a number of lower-cost workers had withdrawn voluntarily from participation in their employer group, or in response to their competitors' actions.

Who Might Become Uninsured

Where employers drop health insurance coverage, some workers probably will not be able to afford new coverage and, as a result, will become uninsured. The expert participants generally agreed on who would be most likely to become uninsured if their employers stopped providing:

- **Modest- and low-income workers** who face high out-of-pocket costs for individual coverage because they are older or sicker, along with some younger, modest-income workers who do not qualify for a substantial tax credit, would be most likely to become uninsured.
- **Dependent children of workers who become uninsured, or obtain individual coverage**, are also at risk. Medical care access is generally enhanced where children are covered through the same source as their parents, and parents with non-group coverage are far less likely to obtain family coverage than are parents with employer coverage. Further, the proposed tax credit levels would not be adequate for the comprehensive coverage that is particularly important for low and modest income children. And while S-CHIP is a critical coverage source for children, many displaced children would likely be excluded by program income or enrollment limits.

Major Uncertainties and Divergent Views

An important conclusion reached by the expert panel is that we simply cannot predict with a high degree of certainty what the effects of the proposed tax credit will be.[2]

- While there is agreement on the *direction* of these effects, there is significant uncertainty about their *magnitude*.

- In addition, the uncertainty is compounded when the panelists looked at second- and third-generation effects.

This uncertainty produced significant differences in opinion about the downside risks of the Bush administration's proposed tax credit. Some panel members believe that the number of people who might lose coverage is so small (in both the short run and the long run) that it is not a significant policy consideration. Other panelists believe that the number of people who become uninsured as a

[2] Estimates of the number of individuals becoming uninsured due to loss of employment-based coverage ranged from 1.4 million (Gruber, 2002) to "minimal" (Council of Economic Advisers, 2002).

result of the dropping of employer-based health insurance may be somewhat larger but is inconsequential relative to the larger number of individuals who would become newly insured under the proposed tax credit.

Still other panel members believe that loss of employer coverage could be a problem that escalates over time and could even end up *increasing* the total number of people without health insurance coverage. These second- and third-generation effects could result from competitive responses to those employers that had initially dropped coverage. Declining employer contributions and deterioration of the risk-pooling mechanism could escalate into widespread erosion of the social contract for employment-based coverage.

Given the lack of a solid empirical base for predicting employer and employee responses to an individual tax credit, it is not surprising that even the estimating models of highly capable researchers yield different predicted outcomes. As a senior economist for the Administration noted, different behavioral assumptions in estimating models can yield quite different results that are not a reflection of policy differences but, rather, are a reflection of differences in assumptions and model structure.

Modifications to Reduce Downside Risks

Panel members discussed a variety of possible modifications to the proposed tax credit.

Some suggestions sought to **minimize the number of workers and employers who would drop employment-based coverage** in response to the new tax credit.

- Making the tax credit applicable to employer as well as individual coverage, so that lower-income individuals would not receive higher tax subsidies for individual coverage than for employer coverage.

  If generally applicable, such an extension would greatly increase tax outlays. To contain the cost, the option could be limited to those employer groups otherwise most likely to drop existing coverage, e.g., low-wage employers. Panelists noted that the decision regarding who does or does not qualify would be controversial, and the resulting design might be subject to "gaming."

- Making employees who are eligible for employment-based coverage ineligible for tax credits, or prohibiting employers from discriminating against workers eligible for the tax credit with respect to health insurance eligibility or contributions.

  Such policies could hypothetically obviate the risk of shifts from employer coverage, but would be difficult to enforce and could create incentives for some employers not to offer coverage at all.

Other suggestions aim **to maximize the number of tax-credit-eligible persons who obtain individual coverage**.

- Adjusting the tax credit so it provides assistance proportionate to the non-group premium cost faced by a given individual.

  Either adjusting the credit for multiple factors (e.g., health, age, and/or geography) used to determine non-group premiums, or paying a substantial percentage of whatever premiums were incurred, could increase the number who can afford coverage. But the former approach would be extremely complex to administer, and either approach would be much more expensive for government than the current proposal. Further, either could greatly increase the number of individuals and employers who would find it attractive to drop employer-financed coverage. An easier to administer option would be to adjust the credit for age only. A more affordable option might be partial age adjustments.

  Automatic enrollment mechanisms, such as placing individuals without employer coverage in a health plan unless they proactively elect to remain uninsured and using employers as a vehicle for such enrollment (whether or not they sponsor a plan), were suggested as a way to maximize coverage among tax-credit recipients. However, other participants observed that, unless such measures were tied to an option to apply tax credits toward employer-sponsored coverage, they could incent employers to substitute tax credits for their own contributions while still appearing to offer "job-based" coverage. This could greatly increase tax expenditures and cause the coverage displacements discussed earlier.

Although there was insufficient time at the expert forum to consider these ideas in depth, it was observed that each of the suggested modifications had positive and negative features. Furthermore, panel members agreed there is an underlying tension between different coverage objectives and the effects of alternative tax-credit formulas, and that difficult trade-offs are involved in selecting an acceptable, effective design for an individual tax credit.

Uncertainties about the effects of a tax credit for individual health insurance cause some panelists to believe the policy should *not* be pursued because it might undermine the employer-based health insurance system. Other panelists suggested either phasing in the policy so its effects can be better studied, or making its design flexible enough to allow adjustments to be made easily as the policy's effects and costs became better understood. Still other panelists posited that *any* policy whose goal was to expand coverage significantly among the uninsured would have ramifications for employer-based coverage, and that new policies to help the uninsured should be tried despite the uncertainty involved.

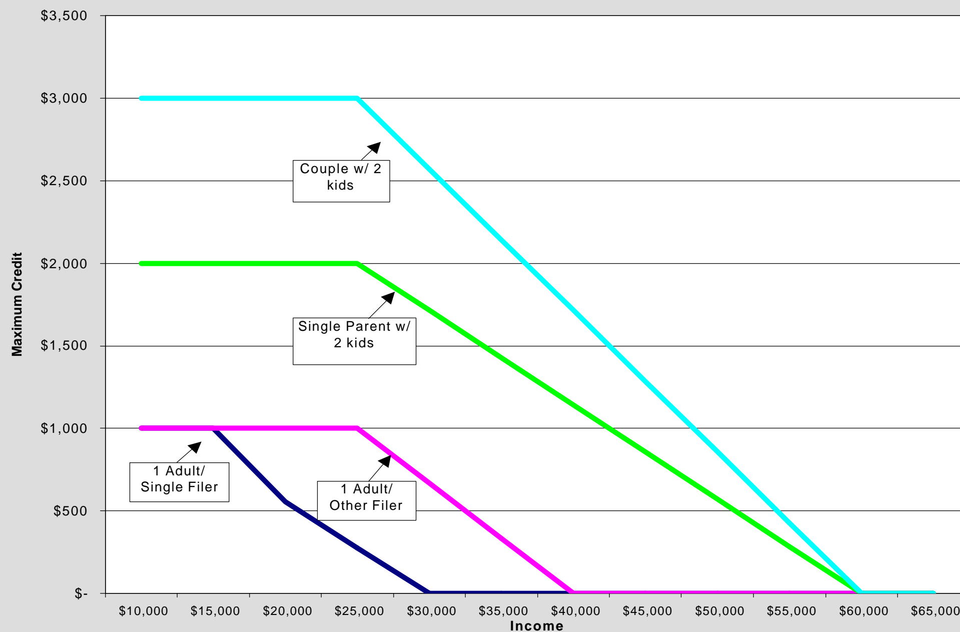
The panelists generally agreed that, to the extent they can be identified, workable approaches to minimize potential loss of coverage should be incorporated into the tax-credit proposal. It is noteworthy in itself that two dozen accomplished experts took the time to participate in a constructive effort to better understand the factors involved in this issue and the potential for workable solutions.

I. Background and Context

This section provides details about the structure of the tax credit included in the Bush administration's FY2003 budget and other relevant background information provided to the participants in advance of the forum.

The proposed tax credit pays a maximum of 90% of the premium amount, up to a cap of $1,000 per adult and $500 per child, with a two-child maximum and a $3,000 family maximum. To be eligible, the health insurance policy must be for individuals under age 65 who do not participate in a public or employer-provided plan. Eligibility also depends on the taxpayer's modified adjusted gross income and filing status. Single filers earning up to $15,000 qualify for the maximum 90% credit; other filers can earn up to $25,000 and qualify for the maximum credit. The credit phases out completely at $30,000 for single filers, $40,000 for other filers purchasing only a single adult policy, and $60,000 for all others (see **Figure 1**). Because the tax credit is refundable, the amount of credit realized does not depend on the tax liability of the recipient (similar to the design of the earned income tax credit).

Figure 1: Value of the Tax Credit by Income for Selected Family Compositions



Note: The illustration assumes that the premium expense is high enough to qualify for the maximum credit (e.g., $1,111 for single policyholders).

Source: IHPS Illustration based on Department of the Treasury, 2002.

As **Table 1** illustrates, these income eligibility criteria represent a range of poverty levels depending on family size. The maximum tax credit would be available up to 138% to 209% of the poverty

level, depending on family structure, and eligibility for a 50% credit would extend well above 200% of poverty.

Table 1: Proposed Health Insurance Tax Credit Income Thresholds Expressed as a Percent of Poverty

Policy Type/Filing Status	Eligible for Full (90%) Credit	Eligible for 50% Credit	Ineligible for Credit
Single Adult/ Single Filer	169%	226%	339%
Childless Couple	209%	340%	503%
Single Parent with 2 Children	166%	270%	399%
Couple with 2 Children	138%	224%	331%

Source: Department of the Treasury, 2002; Department of Health and Human Services, "2002 HHS Poverty Guidelines" (accessed from *http://aspe.hhs.gov/poverty/02poverty.htm*).

Low-Income Young Adults

Because age and income are highly correlated, young adults with low incomes account for a large portion of the low-income uninsured. **Table 2** shows that 29% of those between the ages of 19 and 29 are uninsured—roughly twice the uninsured rate in the older age groups. As a result, adults between the ages of 19 and 29 who are under 200% of poverty are the largest single group of uninsured, representing 27% of all uninsured adults.

The proposed tax credit will be most attractive to those who can command less expensive premiums in the non-group market and who qualify for a significant credit. In most states, those who are young, healthy, and male are eligible for the lowest non-group premium rates.[3] These premium rates reflect the fact that health care costs increase with age.

[3] In 2000, 15 states limited rate variation in the individual market, but only two (New York and New Jersey) required pure community rating (allowing no variation for age except for differential child/adult rates) (Chollet, 2000).

Table 2: Adults: Percent Uninsured and Percent Distribution of Uninsured Adults, by Age Group and Income

Age Group	Percent of Age Group Uninsured	Percent of All Uninsured Adults	
		<200% FPL	200%+ FPL
19-29	29%	27%	10%
30-44	18%	21%	15%
45-64	14%	14%	12%

Source: IHPS analysis of March 2000 Current Population Survey.

Parents vs. Non-Parents

As seen in **Table 3**, for all income ranges above poverty, parents are more likely to have employer coverage and are less likely to be uninsured than are non-parents with the same income levels. Thus, to the extent employers drop coverage, parents are proportionately more likely to be members of the group that loses coverage.

Table 3: Rates of Employer Coverage and Uninsurance among Parents and Non-Parents, by Family Income, 1999

% FPG	With Employer Coverage		Uninsured	
	Parents	Non-Parents	Parents	Non-Parents
<100%	19.1%	27.9%	41.3%	43.0%
100%-132%	42.6%	32.1%	34.4%	35.0%
133%-199%	60.6%	41.5%	26.2%	36.1%
200%-249%	74.1%	57.3%	15.8%	27.6%
250%-399%	86.1%	71.2%	7.7%	17.3%
400% +	91.0%	85.3%	3.8%	8.2%
TOTAL	**73.1%**	**63.3%**	**14.8%**	**21.7%**

Source: IHPS analysis of the March 2000 Current Population Survey.

II. Assessing the Risks

The questions posed to the meeting participants focused on (1) whether anyone with employer-based coverage might become uninsured as a result of the policy; (2) if so, the characteristics of those at greatest risk; and (3) whether certain modifications of the tax credit design might alleviate that downside risk.

To facilitate a productive dialogue regarding the design of the tax credit, the meeting did not focus on other alternative approaches, such as major new public program expansions, or on important complementary policies, such as reform of the individual market. (While reference was made to an analogous possibility that a significant share of spending on Medicaid expansions to the non-poor could merely substitute for existing employer coverage, that issue was not discussed in any depth at this forum.[4] *)To provide some context for the discussion, participants agreed to a few "working" assumptions regarding individual market rules and mechanisms, particularly with respect to access and renewal of coverage.*

Generally, it was assumed that market rules would be in place such that the non-group market functioned in a socially acceptable way, and carriers could participate in the market and remain viable. More specifically, it was agreed that, at a minimum, guaranteed access to individual coverage would exist within relative price limits, for example, through an accessible, adequately funded high-risk pool or market access and rating rules, and, once an individual had coverage, the carrier could not impose a surcharge at renewal due to that individual's health status or claims experience.[5]

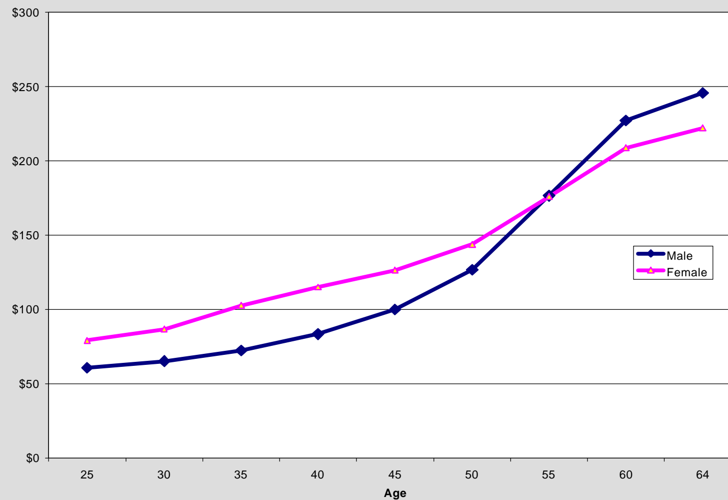
Which workers have the strongest incentive to drop employer-based coverage?

In the non-group insurance market, with full age rating, the premium for a healthy 64-year-old male can be as much as four times the premium for a healthy 25-year old male (**Figure 2**). Note that while men's premiums are cheaper than women's in their younger years, they face a steeper rate of increase as they age. Because the proposed tax credit amount does *not* vary with age (for adults) or gender, among those who do not already have individual coverage, the credit will be proportionally more attractive to younger adults. In most states, insurers can also use health status to determine the premium at the time of initial application, suggesting that this will also be an important factor in who finds the credit attractive.

[4] Readers interested in this topic can find two related papers in the Appendix A bibliography at the end of this report. One article (Kronick) reports estimates of crowd-out by income level under earlier Medicaid expansions to adults. The other report (Neuschler) assesses the dynamics involved and identifies alternative policies to address them in the context of California parental coverage expansion options.

[5] The Health Insurance Portability and Accountability Act (HIPAA) prohibits insurance companies from refusing to renew coverage because of the health status of an individual or a group. Guaranteed renewability does not prohibit premiums from being raised, however.

Figure 2: Illustration of Impact of Age and Gender on Premium Cost

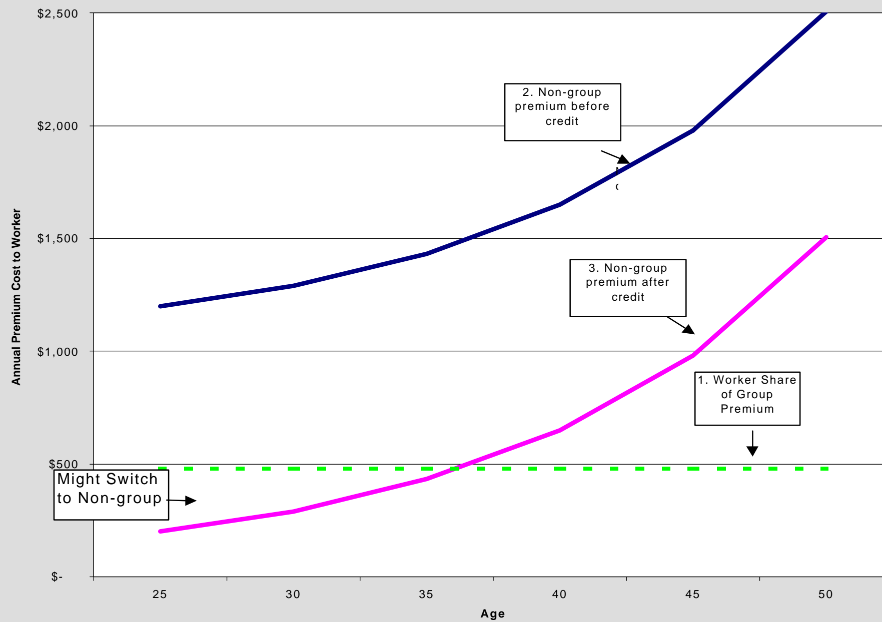


Source: Mutual of Omaha. These illustrative premiums have been stylized by setting the premium for a 45-year-old male equal to $100 per month. These premium factors would have to be multiplied by a geographic factor and adjusted for actual deductible level (e.g., $1,000, $2,500) to produce an actual premium for a real person in a particular locality.

In contrast, within an employer group, worker contributions to health insurance do not generally vary by age, sex, or health status (line 1 in **Figure 3**). Hence, those who are the least costly risks typically subsidize the premiums of older and sicker workers. Despite this phenomenon, employer coverage usually remains more attractive to low-cost younger workers than non-group coverage because of the employer contribution and the lower administrative costs associated with group coverage.

As Figure 3 illustrates, however, the $1,000 tax credit could lower the net cost of an age-rated non-group premium sufficiently to make it more attractive than the employer-subsidized premium for younger workers (from line 2 to line 3). Lowering the post-credit cost of insurance below group rates is more likely if workers must make a substantial contribution to their employer-sponsored coverage. Also, for workers in small firms, the administrative cost advantage over the individual market is not as great as it is for larger firms. Last, if the worker lives in an area with lower health care costs, the tax credit is proportionally more valuable, making substitution more likely.

Figure 3: Illustrative Impact of Tax Credit on Group/Non-Group Premium Choices, by Age



Note: This IHPS illustration assumes the policyholder is eligible for the full tax credit and is low risk.

The tax treatment of the worker's contribution to health insurance will influence the likelihood of substitution as well. If the employee's contribution receives favorable tax treatment under a "premium only plan," the employee is less likely to substitute non-group insurance, all other things being equal.

Important to this discussion is the ease with which workers could obtain wage increases in lieu of the employer's health insurance contribution. Panelists felt that ultimately most workers "paid" for employer coverage (at least partially) through lower wages. If workers can recapture these lost wages easily, the likelihood of substituting non-group insurance for employer-sponsored coverage increases. Panelists noted, however, that this theoretical trade-off often might not work in a timely fashion for an individual worker.[6] On the other hand, within a small firm, it might be possible to make informal agreements to substitute wages for health insurance contributions.[7] In a similar fashion, if the employer offers health insurance as part of a cafeteria plan, workers may have the ability to use their employer's contribution for other fringe benefits or cash—increasing the likelihood of finding the non-group insurance attractive. Cafeteria plans, however, are largely confined to larger firms. The panelists thought such firms were unlikely to change their health insurance sponsorship even if some younger workers dropped coverage.

[6] Nor was there widespread agreement on how to measure the potential wage increase. Did it represent a fixed percentage of the premium, or was it proportional to expected claims cost (i.e., older workers could expect proportionally more wages for forgone employer coverage)?

[7] This would, of course, generate a tax consequence. Both the employee and employer would have to pay FICA on the wage increase in addition to income tax—taxes not levied on the employer's former contribution to health insurance.

How will employers react?

Forum participants generally agreed that it is difficult to predict how employers will respond to the new tax credit.

From a purely economic point of view, one may assume that employers seek to maximize the efficiency of the compensation package. This implies that the employer will be inclined to drop coverage if employees can take the tax credit and (potentially) cash out the previous employer contribution, and will be better off buying coverage in the individual marketplace.

However, several panelists noted that most firms are unlikely to be homogeneous with respect to their worker characteristics. Even among firms with a significant number of employees who would benefit from the credit, there are likely to be other workers who are ineligible for the credit or would be worse off in the non-group market because of the premium they would be offered.

A key unknown is how employers aggregate the preferences of their workers in such situations. In addition, most employers are not simply profit maximizers. Many tend to be paternalistic and offer health insurance whether or not it makes sense for every worker.

> **[Those with an] incentive to drop coverage are going to be small employers and low-wage employer groups.**
>
> ***—Jim Mays***

Nevertheless, there is a subset of employers who have a high concentration of low-wage (and, therefore, potentially credit-eligible) workers and do offer health benefits.[8] Panelists agreed that the employers most likely to substantially change their health insurance coverage substantially in response to the tax credit are small, low-wage employers. For these employers, the loss of a few young, low-cost workers might substantially raise premiums,[9] and they might have difficulty meeting minimum participation thresholds.[10] The relative attractiveness of the credit for these workers is enhanced by the current tax exclusion for the employer's health insurance contribution, which is much less valuable to low-wage workers than to high-wage workers. In addition, the premium loading factors faced by small employers are significantly higher than those for large groups, reducing the group rate advantage over the non-group market.

[8] Long and Marquis, 2001

[9] Although most states limit the degree to which insurers can rate small groups for health status, only a handful of states sharply restrict age as a rating factor. Thirty-seven states have a rate band of some type (either age or composite.)

[10] The formula carriers are permitted to use to calculate participation varies from state to state. In some states, workers with other coverage are not included in the participation formula. The exclusion can vary with the type of coverage. Minnesota, for example, excludes from the count of eligibles those with coverage from another employer or public program but includes those with non-group private coverage (i.e., such workers count in the denominator of the participation rate calculation.) Montana, on the other hand, requires that carriers also exclude from the count of eligibles those with non-group private coverage. Thus, if a group previously had eight of 10 eligible workers participating in a plan, but two "leave" for individual coverage, the participation rate would drop from 80% to 60% in Minnesota. In Montana, however, the new participation rate would be six out of eight eligible workers, or 75%.

"Marginal" employers – those who would consider dropping coverage in the future – also might have a lower-than-average health insurance contribution, adding to the likelihood of substitution among their workforce.[11]

All in all, most participants thought that number of employers substantially changing their health insurance sponsorship would be small initially. A few participants thought that a significantly larger number might use the advent of the individual tax credit as an occasion to drop coverage – whether or not they had a majority of workers who would be better off buying coverage in the individual market.

Who is most likely to become uninsured/underinsured?

Workers now facing higher prices could get another job at a firm that hasn't dropped coverage … if the labor market is flexible enough.

—Mark Pauly

If an employer drops coverage or significantly increases employee premium contributions, some workers would buy insurance in the individual market or switch to a spouse's policy. Others might change jobs to regain employer-sponsored coverage. The panel discussed the extent to which workers' choice of jobs reveals the strength of their demand for health insurance and, by extension, their likely behavior if their job-based coverage was withdrawn. One hypothesis is that workers, realizing they pay for employer-sponsored health coverage through lower wages, "sort" themselves into jobs that do or do not offer health insurance based on their preference for health insurance vs. higher wages.[12] If this sorting worked perfectly, then all workers whose employers dropped health benefits would take steps to regain coverage (reflecting their strong preference for health insurance), and virtually none of them would become uninsured.

There's surely some sorting going on, but the research evidence seems to indicate that it is highly imperfect.

—Linda Blumberg

But there was little agreement among the experts about how well "sorting" works. As one panelist pointed out, there seems to be evidence that this phenomenon does *not* work perfectly. For example, many people who don't value health insurance are in firms that offer health insurance (including workers who decline coverage available to them).[13] More to the point, in another survey, 66% of those *without* health insurance claimed it was very important.[14] Labor market conditions and lack of marketable skills might contribute to an imperfect sorting of workers into jobs that mirrored their health insurance preferences.

[11] A number of small firms also have high employer contributions to maximize participation in the group.

[12] Whether this is an optimal outcome depends on whether society values an individual's health insurance more or less than the individual does. The panelists generally agreed there is a benefit to society to insuring even those who place a low individual value on insurance. Accordingly, coverage programs may want to subsidize insurance at rates that exceed the individual's valuation of insurance and structure enrollment to encourage participation.

[13] Monheit and Vistnes, 2000; most economists believe workers give up some wages in return for a health insurance offer and, hence, are worse off if they are in a job that offers health insurance but they don't take the offer.

[14] "Health Insurance Coverage in South Dakota," final report to the State Planning Grant Program to the U.S. Department of Health and Human Services, prepared by the South Dakota Department of Health and The Lewin Group, March 29, 2002.

Hence, most panelists believed that some workers would become uninsured or underinsured. Forum participants classified the potentially uninsured into two groups: those who could afford the insurance but place a low value on having it, and those who value insurance but would find it difficult to afford. The former group might include the risk takers who are young, healthy, and single. It should be noted, however, that these workers—by definition—purchased employer sponsored insurance in the recent past, so they theoretically value insurance at least up to the level of their former contribution.

One panelist emphasized that even if it is economically advantageous to purchase coverage in the non-group market, people often don't go to the trouble of initiating the purchase. This panelist cited studies showing that when faced with equal tax incentives to participate in Individual Retirement Accounts or employer retirement plans, participation in the latter was much higher due to the lower "hassle" factor.[15]

Those finding it difficult to afford adequate non-group coverage might include the low-income, those with expensive health insurance needs (e.g., unhealthy or older), those in high-cost areas, those ineligible for a significant credit, and those without an insurance option through a spouse. Some participants pointed out that those with high insurance needs often are willing to pay more for insurance than those with low health insurance needs—all other things being equal. It was also noted that insurance is often a better actuarial value for older people.[16] Even if they are able to regain coverage, financial hardship or under-insurance may be significant problems for these groups if their employer drops coverage.

Several models have attempted to estimate the impact of a tax credit on employer-sponsored coverage. Yet, as pointed out above, we can't say with much precision how many of those with employer coverage might take the credit and how many might become uninsured as a result of decisions made by employers. As one panelist pointed out, we know a fair amount about how and for whom relative prices will change as the result of the tax credit but we don't, in fact, know how people will behave in response to these changes and related non-economic factors.[17]

Special considerations for children and their parents

Another panelist noted that child dependents may be particularly vulnerable. Data show that in the group market, policyholders with families buy family coverage 73% of the time (the remainder purchase single coverage).[18] In the non-group market, however, policyholders with families buy family coverage only 32% of the time. In some cases, the failure to purchase a family policy in the non-group market may be because some of the family members have coverage elsewhere—such as

[15] Unpublished analysis of Statistics of Income (SOI) data and Employee Benefits Research Institute data by Eugene Steuerle, Urban Institute.

[16] Pauly and Herring, 2002.

[17] One panelist cited recent research on the loss of SCHIP enrollees at renewal time. Focus groups revealed that even though these families valued insurance, liked the program, and were eligible for zero premiums, they just didn't "get around" to renewing.

[18] Unpublished tabulations of the March 1999 Current Population Survey by the Urban Institute.

Medicaid or the State Children's Health Insurance Program (SCHIP). It was pointed out that, while SCHIP provides an important health coverage safety net for low-income children, placing children in separate health plans from their parents can undermine the children's access to medical services.[19] Furthermore, children are the primary beneficiaries of the preventive coverage and low copays typically associated with a comprehensive employer plan.

Predicting the impact of the tax credit on families is more difficult than predicting its impact on singles. If a family is eligible for the credit, at least some members are also likely to be eligible for Medicaid/SCHIP. Hence, families with access to employer coverage may be choosing among three coverage options—options that do not lend themselves easily to comparison. Eligibility for the tax credit uses the same rules for the whole family, whereas Medicaid/SCHIP eligibility varies among family members. On the other hand, both Medicaid and SCHIP coverage are likely to be much more comprehensive, and have a substantially higher actuarial value, than the minimum policy associated with the $500 credit per child proposed in the president's budget.[20] Furthermore, the tax-credit amount is capped at $1,000 for coverage for two or more children, whereas SCHIP coverage is available to all income-eligible children for a modest premium, regardless of family size. In the non-group market (and, to a lesser extent, in the group market) family rating structures vary tremendously. In some cases, premiums would be the same for all family units with two or more children. In other cases, premiums are greater for those with more children. They may or may not parallel the two-child maximum associated with the tax credit. For these reasons, several panelists cited the need to coordinate the tax credit with children's coverage programs.

Some families may find it economically advantageous to use the tax credit for a "parents-only" policy and enroll their children in public programs. As noted earlier, households of more than one person that purchase a single adult policy in the non-group market are eligible for the full tax credit at higher incomes than those whose filing status is "single." Note that the administration's proposal would allow states to set up a parallel "purchasing pool" for the parents of SCHIP program recipients, and would allow the parents to apply their tax credits to enroll in the same (private) health plan as their SCHIP children (discussed further below).

What are the possible long-term effects?

Most panelists felt the first-round effects on employer coverage would be small, although some were concerned that large numbers of employers might use the tax credit as the occasion to drop coverage. Absent a good model for employer decision making, however, the group could not reach consensus on the extent of the potential problem over the longer term.

> **Unless you have a mechanism that will do a better job of pooling people and getting insurance to them, I would be very cautious about instituting policy changes that hold out a genuine possibility of causing [the employer-based] system to unwind.**
>
> ***—Henry Aaron***

Faced with uncertainty regarding employer behavior, participants' views ranged considerably. Because employer sponsored insurance covers so many people, it was felt that even small changes

[19] Hanson (1998) found that children are more likely to use care if their parent uses care. Common sense suggests that parents will find it easier to access care for their children if they are familiar with the health plan's structure because they use it for themselves.

[20] Administration officials pointed out that the proposed tax credit is not intended to provide "first dollar" coverage.

at the margin could have a potentially large impact over time. Others believed the effects of the tax credit were too small to engender significant long-run effects on employer coverage. It was noted that none of the modeling efforts to date has attempted to estimate long-term effects.

Other possible long-term effects were discussed briefly, including possible adaptations by the individual insurance market and possible responses by state health care programs. Several participants pointed out that the effects of the tax credit could not be examined in isolation. Declining marginal tax rates and other aspects of incremental health reform (such as Archer MSA expansions) will have an impact on any long-term effects.[21] A key unknown raised by one panelist was the tax treatment of employer contributions to plans they don't sponsor.[22] Another participant noted that a large part of the small employer market—the self-employed—would be moving into fully tax-subsidized status, and this would increase the extent of coverage among employers, all other things being equal.[23]

[21] See Lyke, 2001 for some of this background.

[22] Currently, it is unclear whether or not an employee must pay tax on an employer contribution to a health plan they don't sponsor. If the IRS were to decide that such contributions were not taxable, this could have a large impact on the willingness of small employers to contribute to health insurance and, more generally, the sponsorship of health insurance by employers.

[23] This scheduled change in tax law will put the self-employed on a similar but not equal footing with incorporated businesses. The self-employed will still have to pay FICA taxes on the money used to pay health insurance premiums, whereas workers in incorporated firms do not pay FICA on some (or all) of their premium payments (depending on whether the employee share is paid under a section 125 plan).

III. Reducing the Risks

Meeting participants suggested a range of possible policy modifications to minimize the loss of employer-sponsored coverage and enhance coverage in other ways. The resulting "toolbox" of ideas has substantial breadth and scope and should prove useful for policy makers.
The modifications proposed during the meeting can be grouped into three broad approaches:

- strategies to minimize the incentive for **employees** to drop employer coverage[24];
- strategies to minimize the incentive for **employers** to drop coverage; and
- strategies to maximize coverage among those faced with the loss of employer-sponsored coverage.

It should be noted that the time frame of the meeting did not permit an in-depth discussion of the pros and cons of each alternative.[25] Many of the suggestions were not administratively simple; others were likely to add significantly to the cost of the proposed program. **Appendix A** lists several papers that consider the pros and cons of some of the suggestions more extensively. As noted above, to focus the meeting on its stated topic, the agenda did not address possible reforms to the non-group insurance market.

[24] As one panelist pointed out, there may be cases where dropping employer coverage should not be considered a "bad thing." For example, certain features of non-group insurance, such as choice and portability, may also have very high value for certain individuals. Where an employer offers only a high-deductible plan, substituting a comprehensive non-group policy may have a net benefit to the individual as well as to society.

[25] Before debating possible modifications, participants briefly discussed the criteria to be used to evaluate the proposed modifications. This discussion included desired policy outcomes as well as measurement criteria that should be used to evaluate the policy effects. Most in the group felt that the "measurement criteria" could usefully be distinguished from the policy goals. For example, "cost per newly insured," "number newly insured," "net reduction in the uninsured" are all important to measure/estimate, but they may be different from the policy goals (e.g., provide a horizontally equitable coverage alternative to low-income people). Much of the discussion focused on the necessary trade-offs between equity and efficiency. For example, if an already insured person were eligible for a substantial credit, it could divert scarce public dollars from an uninsured person—an inefficient, yet equitable outcome.

While this did not constrain the discussion, an administration official noted that the proposed tax credit will cost an estimated $100 billion over 10 years. Administration officials indicated that, in light of the policy of incremental health care reform and other fiscal priorities, there was not much leeway to increase the cost of the program.

Minimizing the incentive for employees to drop employer coverage

A number of suggested modifications sought to minimize the incentive for workers to drop employer-sponsored coverage due to the proposed tax credit for the non-group insurance. One suggestion was to **permit the tax credit to be used to purchase employer coverage** (either in lieu of or in addition to current tax preferences for employer coverage).[26] Issues raised with this approach include the considerable cost increases, reduced target effectiveness, and equity considerations. Employer-sponsored coverage is already tax favored, although the tax advantages are generous to higher-income persons and relatively low for those who would be eligible for the full proposed tax credit. A number of participants thought it would be desirable to replace the current tax treatment of employer health insurance contributions with a progressive tax credit. administration officials indicated that such a policy went far beyond the current "incremental" approach to health care reform. Although this approach has been suggested by some of the participants over the years, it was also observed that such a change in tax treatment (often entailing a "cap" on tax breaks for employer coverage) is very controversial.

Conversely, **the tax credit could be denied to those who have the option of employer-sponsored coverage**. This could be difficult to administer, however, and might have unintended consequences contributing to a loss of coverage.[27] This approach would penalize employers and workers who had historically obtained coverage and reward those who had not. In the longer run, as firms adapt their benefit packages, and as workers select new places of employment, such a policy is unlikely to be successful.

Other ideas would **modify the formula for the tax credit** to better mirror the prices faced by workers in the non-group market. For example, adjusting the credit by some or all of the factors used to determine premiums in the non-group market (age, sex, health, and geography) might reduce the concentration of "switchers" among workers with certain characteristics. An age adjustment, in particular, had several supporters. Proponents pointed out that this would be easier to administer than other types of adjustments and that precedent for it exists in the tax code.[28]

Some participants questioned whether it is desirable or necessary to change the tax credit to make insurance more affordable for older people if the policy goal is to maximize the number of newly insured. As noted earlier, those with high insurance needs are willing to pay more for insurance than those with low health insurance needs—all other things being equal. In addition, insurance is often a better actuarial value for older people (they receive more in benefits per dollar of premium

[26] For example, the Jeffords-Breaux "REACH" proposal contains a similar tax credit for non-group insurance but a *partial* tax credit for employer-based insurance as well (e.g., $400 for an individual for group coverage, $1,000 for an individual for non-group).

[27] Meyer, Silow-Carroll, and Wicks, 2000. Note, however, that the administration's proposal for Archer MSAs would restrict eligibility to employer groups and individuals *who do not have an employer option.* Similarly, the health insurance deduction for the self-employed is only available to those who don't have the option of subsidized employer group coverage. Perhaps more needs to be done to assess the feasibility of such a mechanism.

[28] The maximum allowable deduction for premiums for long-term care insurance varies with the age of the policyholder (Department of the Treasury, Internal Revenue Service, Publication 502).

paid than do younger policyholders.) There was also concern that, if a fully age-rated credit were budget neutral, it would be so small for young adults that it would do little to encourage them to purchase insurance. A more generous age adjusted credit could greatly increase tax expenditures and make it more attractive for older workers to leave employer coverage. Another concern was the high marginal tax rates created by phasing out a much larger credit (for older workers) over the same proposed income range.[29] One suggestion for alleviating these concerns was a *partial* age adjustment. Properly designed, a partial age adjustment would reduce, but not eliminate, the age-related disparities between the group and non-group markets and could supply enough subsidy to increase insurance among young adults while still providing some additional assistance to older workers.

The important point was made that state insurance regulations affect non-group (and small-group) insurance prices differently. As a result, any adjustments to the credit might have to vary at the state level. Perhaps this might be implemented by providing a supplemental grant to the states that could be used to augment the credit for older workers.[30] A related idea would put states "at risk" for any unraveling of the employer market (vis-à-vis their individual and small-group market rules).

Another suggested alternative was to specify the credit as a percentage of the premium (capped at a much higher amount, if at all).[31] This would adjust the credit automatically for the relative prices faced by those purchasing in the non-group market. For this approach to work, however, either the budget for the tax credit would have to be greatly expanded or, if budget neutrality was to be preserved, the percentage would have to be so small that significantly fewer people would be newly insured as a result of the change (i.e., a higher proportion of spending would go for those who already had individual coverage). Many participants felt that an "open-ended" obligation (i.e., a substantial percentage with no cap) would not be cost-effective and might lead to the over-consumption of insurance.

Another suggestion would tie the size of the credit to both individual worker earnings and family income. In families that meet the income eligibility guidelines, if both adults work, they both are likely to earn low wages. In this case, since the likelihood of employer coverage is strongly related to wage, they are more likely to be uninsured than families with one full-time worker and the same family income. If the credit were phased out more rapidly for one-worker families, with their higher earnings and higher likelihood of employer-sponsored coverage, then there should be less substitution of non-group insurance among those with employer coverage.[32] Some panelists felt there were significant administrative difficulties and equity issues with this approach, however.

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[29] The proposed tax credit combined with the phase out of the Earned Income Tax Credit generates marginal tax rates over 40% for families under 200% of poverty when combined with their 7.65% FICA obligation.

[30] Or, as one participant suggested, the entire credit might be transferred to the states, which would then have the latitude to make adjustments and, if desired, supplement the credit further with state money.

[31] The administration's proposal is, of course, designed as a percentage with a cap. The cap is low enough, however, that most of the panelists felt it would function effectively as a flat credit amount.

[32] Curtis and Neuschler, 2002.

Panelists did point out that some of the modifications that make the non-group credit less attractive for those with employer coverage may also lower take-up rates among the uninsured with no employer option.

Minimizing the incentive for employers to drop coverage

As discussed earlier, if the proposed tax credit were adopted, some employers might drop their group coverage or reduce their contributions because a significant proportion of their workers would be better off buying non-group coverage with the tax credit. Other small employers might drop coverage because of the increase in premiums or reduced participation resulting from low-cost workers taking up non-group coverage. Under either scenario, some workers of such employers might become uninsured.

To the extent that policies are adopted to reduce the incentive for *employees* to drop employer-sponsored coverage (as discussed above), this should also reduce the incentive for *employers* to drop coverage. Separately, the panelists also considered options to discourage employers directly from dropping coverage. For example, one participant suggested either **penalizing the employer if it drops coverage or compensating the employer if it experiences erosion of its group** because of the tax credit. Panelists pointed out that such approaches pose substantial equity and administrative difficulties (for example, an employer would have to demonstrate that the tax credit was the reason for the erosion).

Another participant suggested **creating a small credit for small, low-wage employers to encourage them to continue (or begin) to offer coverage**. Panelists noted the problems that states have experienced with such policies, however.[33] If the credit is particularly generous, it was noted, who does or does not qualify would be controversial, and the resulting design might be subject to "gaming" (e.g., large firms might split themselves into legally discrete parts to benefit from the credit).

An alternative idea targeted employers that had a majority of workers for whom the tax credit was more valuable than current tax deductibility of the employer contribution. The proposal would give **small employers the option of choosing between the current tax treatment of employer contributions** (i.e., not treated as income to the employee and thereby exempt from income taxes) and **application of individual tax credits toward the group coverage premium**.[34] Employers that switched their group to the latter scenario would report their contributions to the group premium as income to the employee. The employee would be required to pay income tax on those contributions as wages. To preserve an incentive for the employer to continue contributing to group coverage, however, such contributions would still be exempt from FICA taxes.

[33] At least two states, Oregon and Kansas, have adopted limited tax credits as a means to encourage uninsured small firms to adopt coverage. To date, take-up has been low. See also Meyer, 2000 and Butler, 2001.

[34] Curtis and Neuschler, 2002.

Another panelist suggested **tightening discrimination rules** so employers could not selectively drop some workers from their group health insurance coverage.[35] It was also noted that other proposed incremental health reform features, such as tax-favored health accounts, might make employer coverage more attractive and help to minimize crowd-out.

Maximizing coverage among those without employer coverage

Another group of ideas focused on maximizing the coverage of those who do not have, or who have involuntarily lost, employer coverage. (The discussion often included broadening coverage for all under the tax credit, but this paper focuses on ideas applicable to those who may be displaced from employer coverage. Also, individual market rules—which were not the focus of the discussion—obviously would have a major impact.)

Many suggestions addressed affordability of individual coverage for tax-credit eligibles. As discussed above, many workers with high health care costs will be worse off if they are forced to leave the employer pool. Research has documented that a wide range of plans are available in the non-group market at a wide range of prices. Nonetheless, many panelists were concerned that the amount of coverage that could be purchased for a $1,000 credit would be inadequate.[36] Cost sharing may be too high for those with low incomes, or the coverage may be too limited.[37] Some panelists called attention to proposals that would **limit total out-of-pocket expense for both premiums and cost sharing**.[38]

Others suggested permitting or requiring the credit to be used to "**buy in" to purchasing pools of various sorts, or directly into Medicaid**. The administration's proposal, it was noted, would permit the credit to be used for insurance purchased through private purchasing groups and state-sponsored insurance purchasing pools. While direct purchase of Medicaid or SCHIP coverage would not be permitted, beginning in 2004, states would have the option of allowing certain individuals not eligible for these public health insurance programs to buy into private health plans under contract with state-sponsored purchasing groups such as Medicaid and SCHIP or state government employee plans.[39]

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[35] Self-insured plans stand to lose the tax-favored status of health benefits if they are found to be discriminatory in favor of highly compensated individuals (IRS Code Section 105[h]). Practically speaking, self-insured employers have wide latitude in terms of contribution practices. Non-self-insured plans are not subject to any discrimination rules under IRS code.

[36] As noted earlier, it is not the goal of the policy to fund a comprehensive policy fully for tax-credit eligibles.

[37] Administration officials suggested that "HIPAA creditable coverage" would likely be used to define the type of insurance that would qualify for the tax credit. Acceptable policies would have to include catastrophic protection. This definition is extremely broad and includes insurance that may have limits on benefits or have high deductibles. Short-term, limited-duration coverage is considered "creditable," but limited-scope coverage (such as those that *only* cover dental, vision, or long-term care or provide coverage for only a specified disease or illness) are not considered creditable.

[38] For an example of this type of design, see the supplementary tax credit suggested by Cooksey in H.R. 2250.

[39] Joint Committee on Taxation, 2002.

Such pooling options could reduce the loading associated with non-group plans and reduce premiums for those who are more costly to insure. Furthermore, if the same health plan were available to tax-credit-recipient parents as to their children in SCHIP or Medicaid, this might alleviate concerns about parents and children being under different insurance plans.[40] On the other hand, if participation in pools were optional and states provided no additional subsidies for pool coverage, then the pools would likely experience adverse selection.[41] Low-risk individuals would likely find less expensive coverage in the non-group market, thus leaving higher-risk people in the pools and driving up premiums. A participant noted that the proposed tax credit is too small to fund adequate benefit coverage for the poor. Under the administration's proposal, states could, within limits, supplement the tax credit for low-income pool participants. However, it was emphasized that current state budget constraints are severe and could preclude any additional spending for mechanisms that complement or coordinate with Medicaid.[42]

Distinct from modifications that addressed affordability, several additional suggestions looked at the "process" of insurance enrollment as a means of maximizing coverage. For example, automatic "conversion" policies were suggested to address insurance "transition" points such as job loss, job change, divorce, or when dependents "age off" their parent's policy or Medicaid (similar to the Consolidated Omnibus Budget Reconciliation Act [COBRA] mechanisms).[43] More generally, an **automatic enrollment system** could be structured **to make the purchase of coverage the default option**. By requiring an active choice for those who wished to go without insurance, this system could overcome the substantial inertia factor associated with individual insurance enrollment and could increase coverage among those who don't place a very high value on insurance, as is often the case with young singles. Studies of 401(k) plan participation show an enormous increase in participation when that becomes the default option.[44] Using such a system would require creating a "default plan" which might be a commercial policy or a "buy-in" to Medicaid or a pool.

To simplify the current system for enrolling in non-group insurance (and possibly lower administrative costs) panelists also discussed having **employers involved in the enrollment process—whether or not they sponsor a plan**. This could include mechanisms to permit payroll withholding for the employee's premium, net of any tax credit.[45] To avoid having employers remit payment to multiple health plans, service bureaus could be developed to centralize collection and disbursement of these premium dollars. The service bureau could also maintain and communicate the list of plan options available to purchasers of non-group insurance. It was noted that the "menu" of plan options and premiums would need to be known in advance, hence there could be no

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[40] Weil, 2000.

[41] Additional subsidies could be necessary to reduce out-of-pocket premium costs in the pool to the point where the pool attracts many "normal risk" participants.

[42] In fact, there was concern among some panelists that the federal tax credit might "crowd out" state Medicaid dollars.

[43] Etheredge, 2002.

[44] Choi et al., 2001. Their study showed that switching the *default* 401(k) plan enrollment election to "participating" from "not participating" (preserving the option to decline) increased participation rates by 50 to 67 percentage points. Similarly, more than half elected the default contribution rate and fund elections. As the authors point out, "For better or for worse, plan administrators can manipulate the path of least resistance to powerfully influence the … choices of their employees."

[45] Butler, 2001, and Etheredge, 2002.

individual medical underwriting under this approach. For persons with no worker in the family or without a stable place of employment, other mechanisms would have to be used (for example, a similar withholding process could be used for those receiving an unemployment check).

Some panelists expressed concern that such a system could encourage employers to eliminate their contributions to coverage. Potentially, some employers could see this as an opportunity to replace employer financed group coverage with tax credits for “job-based” individual coverage. In this event, some workers would face higher net out-of-pocket prices for coverage in the non-group market and thus could become uninsured. While efforts might be made to prohibit such actions, some panelists felt appropriate rules would be very difficult to structure and enforce, and could have unintended or unfair consequences. Alternatively, the downside risks might be reduced if such an enrollment system were tied to targeted options for workers to apply tax credits as supplements to employer contributions for group coverage, as discussed earlier.

IV. Conclusions

It is widely accepted that subsidies are needed if modest- and low-income uninsured populations are to afford and obtain insurance coverage. Furthermore, it is generally understood that many uninsured family heads are either employed by a firm that does not offer health insurance coverage or, because of their temporary or part-time work status, are not themselves eligible for employment-based coverage available to other workers. These facts suggest that tax subsidies for individual coverage such as those included in the Bush administration's proposal could be an effective way of helping uninsured people to gain coverage.

Controversy has arisen, however, about whether employers' and workers' responses to the tax credit will cause some workers and dependents with employment-based coverage to lose their existing coverage and become uninsured, and, if so, how great a problem this might be. (There is similar controversy over the effects of Medicaid or SCHIP expansions to non-poor adults.)

Some experts at the April 19 forum posited that the number of individuals who would lose coverage following implementation of the tax-credit proposal is likely to be small compared to the number of individuals who would become newly insured as a result of the proposal. Furthermore, they felt that virtually all workers in firms that dropped coverage would obtain alternative coverage (because their original job choice revealed their strong preference for health insurance). Other panelists disagreed, and some of them suggested there is a real danger that the proposed tax credit could precipitate a downward spiral in the employer contribution and group-risk-spreading arrangements that underpin the coverage of most American workers and their families.

Anything we do to try to assist people who are currently uninsured—whether providing tax credits or expanding Medicaid—is going to have profound implications in all sorts of areas, including the current employer-based system.

—Stuart Butler

The dialogue among panel members underscored an underlying tension between among coverage goals and effects of alternative tax credit formulas:

A tax credit that pays a high percentage of premium up to a low cap. Some advocate this approach because it could achieve coverage of low-income young persons—the population now most likely to be uninsured. While relatively inexpensive coverage is typically available for them, experts generally agree that a very high percentage subsidy would be needed to induce uninsured low-income young (and healthy) individuals to obtain coverage. The Bush administration's proposed tax credit (up to 90% of up to $1,111 in premiums for one adult) is an example of this approach. This approach efficiently targets those most likely to be uninsured. It creates relatively strong incentives for that group—healthy, young, low-income workers—to drop employer coverage if they already have it, but its incentives for other population groups to drop employer coverage are weaker.

A lower percentage tax credit with no premium cap, for example, a tax credit that would pay 60% or 75% of the incurred premium. Some prefer this approach because it would

provide substantially more assistance for persons who are older and who have greater health care needs. These populations generally place a high value on insurance, but face premiums that are unaffordable for low-income persons. Tax expenditures under this approach would likely be much higher per uninsured person covered, however, because both per recipient outlays and the proportion of dollars spent on those who already had individual or employer coverage would likely be greater. Because the average credit amount would be greater, more workers would face relatively strong incentives to drop employer coverage (unless the credit was applicable to employer coverage as well).

These experts agreed that there is substantial uncertainty about the effects of a new individual tax credit on the population with employment-based coverage. Although there is some agreement about the initial effects of the tax credit, too little is known about behavioral responses of employers and workers to predict accurately the magnitude of its long-term effects. As mentioned above, declining marginal tax rates, other aspects of incremental health reform, and the reactions of state policy makers will also influence the long-term effects.

Given the uncertainty about how employers and workers will respond, a number of experts felt it was prudent to explore modifications of the tax-credit proposal that might reduce incentives for employers and workers to drop employment-based coverage. If such adverse reactions could be minimized from the outset, the risk of a cascading erosion of health insurance coverage could be reduced or averted. And some options, such as allowing the credit to be applied toward employer coverage (e.g., under certain limited conditions) could even improve take-up of employer coverage by some now unable to afford the required premium contributions.

Panel members discussed a variety of possible modifications to the proposed tax credit intended to minimize the number of people who might become uninsured because of losing employer-based coverage. Difficult trade-offs are involved in selecting an acceptable and effective policy design for an individual tax credit. And it is very difficult to anticipate the effects of a given tax credit structure across the myriad variations of (and potential changes in) related state policies, or without knowing what other federal policy initiatives for the uninsured might also be adopted.

Nevertheless, this discussion among experts with varying perspectives suggests that, with further careful work, it should be possible to craft an approach that could make coverage affordable for many lower-income uninsured persons not eligible for employer coverage and, at the same time, substantially reduce the risks of precipitating significant reductions in employment-based coverage. By synthesizing their collective efforts and insights, this paper hopes to contribute to that objective.

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